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ABSTRACT

This document is comprised of the four 1997-1998 issues of the Journal of Child-Care Administration, which addresses the concerns of child care centers, learning centers, preschools, nursery schools, kindergartens, and intergenerational centers. Issue 214 includes the following articles: (1) "Turning Your Staff into a Team: The Basics"; (2) "Mildly Ill Children: What Are Our Options? Part 3"; (3) "Productive Parent Meetings: Interview with Dr. Suzanne M. Foster" (4) "'I Am Your Child' Campaign"; and (5) "CPR Training System." Issue 215 includes the following: (1) "Creating and Building a Scholarship Fund"; (2) "Mildly Ill Children: What Are Our Options? Part 4"; (3) "Guidelines for Programs Serving Mildly Ill Children"; (4) "'I Am Your Child' Campaign"; (5) "Staff Teams in Child Care: Children's World Learning Centers"; and (6) "Guide for Childhood Emergencies." Issue 216 includes the following articles: (1) "Including Children with Disabilities: Interview with Susan E. Craig, Part 1"; (2) "Training Materials for Inclusion"; (3) "Update: SIDS and Sleep Position" (4) "'I Am Your Child' Campaign"; (5) "Staff Teams: Stages of Development;" and (6) "Hiring and Training Staff Using Case Studies: Interview with Judy A. Bordin, Part 1: Using Case Studies for Hiring." Issue 217 includes: (1) "Economizing While Preserving Quality: Interview with Victoria Speaks-Folds, Part 1"; (2) "Including Children with Disabilities: Interview with Susan E. Craig, Part 2"; (3) "Excerpts from 'Including All Children' Training Materials"; (4) "'I Am Your Child' Campaign"; (5) "Hiring and Training Staff Using Case Studies: Interview with Judy A. Bordin, Part 2"; and (6) "Staff Teams: Making Decisions." Also included in each issue is information on books of interest to administrators and parents of young children. (KB)

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Christine Kalbaugh, Editor

Issues 214-217

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JCCA JOURNAL OF CHILD-CARE ADMINISTRATION

Issue 214

A National Publication Addressing The Concerns Of:
Child-care Centers Learning Centers Preschools Nursery Schools Kindergartens Intergenerational Centers

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Turning Your Staff Into A Team: The Basics

Is Your Staff A Team?

Should it be? Why or why not?

If it is a team, is it successful?

What, exactly, is a staff team?

The answers to these questions are not as simple as they may seem.

Virtually everyone has heard that teams are the way to run today's businesses. The idea sounds positive, but often there is confusion about the specifics.

A staff team is not simply a group of people who like their workplace and enjoy being together. That is an anticipated result of teams, but the team concept, as it applies to business, involves a great deal more.

Understanding the underlying theory and how it was developed can greatly enhance your success in turning your staff into a highly cohesive and productive team.

This is the first of an ongoing series of articles exploring the **self-directed team**, the work team that has gained the greatest prominence in business today. It is designed to provide a full understanding of the concept and why it has been so widely embraced by the business community.

Are Teams A Passing Trend?

In business and in education, as well as other fields, there are many concepts that become temporarily dominant and then fade into obscurity.

Just as segments of the public are convinced that they must wear the latest fashions, many are also persuaded that the latest professional trend, spurred by the newest book, must be followed. Until that fad is discredited and a new one promoted.

Does the idea of staff teams fit into that category? Should we ignore it because it will soon be replaced by the next popular style of management? **Absolutely not**, say the experts.

Work teams are not a notion concocted on the spur of the moment. They are the product of serious research and study. The idea of teams utilizes what has been observed and learned about workers, and about how people perform under different conditions, over a long period of time. It is taught today in MBA programs and other university courses.

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Evolving Management Concepts

A brief synopsis of how workers have been viewed over time is helpful in understanding how the team concept has gained credence.

Guilds

Before the Industrial Revolution, much of the workforce was arranged around *guilds*. A guild was an association of people in a particular trade. Its purpose was to protect mutual interests and maintain standards.

Each guild made its own rules governing quality, prices and other criteria. Master craftsmen trained apprentices.

Once an artisan completed training, he was expected to abide by the rules and guidelines set by the guild. Within that framework, however, he had the freedom to design and produce unique goods that emanated from his individual talents and creativity.

Factories

In the late eighteenth century, machines began to change the way products were made. In time, *factories* took the place of guilds.

Instead of being members of intimate groups, workers became parts of large organizations in which their personal identities and individual talents were not held to be important. They were told exactly what to do and basically had no say in any aspect of their jobs.

Bureaucracy

By the early twentieth century, ways were studied to manage these large organizations and increase their productivity. A German sociologist, Max Weber, developed the system of *bureaucracy*.

This model became the standard for how all types of work organizations would be structured for most of the twentieth century. It's the one with which we're all familiar. Typically, it is depicted as a triangle or pyramid divided into segments by horizontal lines. At the top is the head of the organization, followed by descending layers of command. In the bottom segment are the workers.

In the bureaucratic system, a person's authority is based strictly on where he or she stands on this pyramid. Those at each level are answerable to those in the level above. The workers at the bottom, of course, have the least amount of power.

Other characteristics of a bureaucratic organization are:

Specialization: The work that a person does is highly specialized and separate from that done by other categories of workers. Someone in the sales division, for instance, does only sales work, and doesn't handle anything related to other departments.

Detailed Rules and Procedures: Management explicitly directs employees in how to do every aspect of their jobs.

Objective Measurement: Promotion is gained by meeting specific, inflexible standards.

Documentation: Communication within the organization and with the public is carried out according to a set of rules, and written records are kept of communication and decisions.

Impersonal Relationships: Managers are supposed to remain somewhat aloof from workers and clients. The rationale is that by avoiding emotional attachments, they will make purely rational decisions.

Steps Toward Teams

While the bureaucratic style of management, based on hierarchy, specialization, rules and impersonal relationships, dominated the twentieth century, there were scholars and others who believed it to be demoralizing to workers and not really in the long-term best interests of the companies that employed them.

Several major experiments were conducted in England, Sweden and other countries. The results strongly indicated that workers in teams, who were given more control over their jobs, were more productive and had better morale and job satisfaction than those in bureaucratic organizations.

Another finding was that companies with such workers tended to have lower production costs and to be more able than traditional firms to cope with changes in society and in the larger business environment.

One of the first steps that US businesses took toward involving employees was in the early 1960s. With the *Quality of Worklife* movement, employers began to ask workers for suggestions on how to make their jobs easier and better.

In the mid-1960s and early 1970s, several large American manufacturing companies began to experiment with self-directed teams.

In the late 1970s, *quality circles* gained prominence. Originated by the Japanese, they were typically composed of workers from different departments of a company who were brought together to find ways to improve quality, service and productivity. These were often temporary teams, and while their input was sought, they generally didn't have the power to implement their decisions.

Gradually, the idea of self-directed teams was coming to the fore. In the mid-1980s, it began to gain wide acceptance by the business community.

What Is A Self-Directed Team?

A self-directed team is a group of two or more people who share decision-making powers and responsibility for significant aspects of their individual jobs, for how their jobs interact with those of other team members and for how their team's contributions affect the overall organization.

Other names for self-directed teams are *empowered teams, autonomous work teams* and *self-managed teams.*

Characteristics of self-directed teams:

They Are Considered Permanent. Unlike quality circles and other kinds of groups, a self-directed team is not created for a limited purpose and then disbanded, or retired until a future need arises. Its members are part of an ongoing, active team for as long as they work for the company.

They Set Many Of Their Own Goals And Determine The Methods They Will Use To Attain Them.

Members Meet Regularly To Plan, Report Activities, Discuss Problems And Strengthen Group Cohesiveness.

They Establish Rules, Roles And Procedures. Teams may be empowered to various degrees. Among the areas over which they may have control are:

- Determining responsibilities within the team
- Absenteeism and other member problems
- Allocating vacation time
- Scheduling
- Recruiting and hiring new members
- Selecting their own leaders
- Setting performance standards for members
- Appraising group performance
- Budgeting
- Training

Members Are Interdependent. They rely on each other's skills. In contrast to workers in bureaucratic environments, who are responsible only for their individual jobs, members of self-directed teams work together to achieve common goals. They need to understand how what they do affects others, and vice versa. They learn aspects of each other's jobs, often rotate various duties, and commonly are asked to temporarily fill in for absent teammates.

The Leader Is An Equal Member Of The Team. A major characteristic that distinguishes a team from other kinds of work groups is its structure.

Other groups are typically structured in one of two ways. In each, the manager or other leader is the central figure.

Dependent Group

In the most basic of groups, the leader tells the members what to do. This relationship can be compared to that between an adult and a group of **children.**

Independent Group

Here, individual group members make some of their own decisions. The role of the leader is more to guide than to dictate.

However, each member must still report to and gain approval from the leader for each project. In this situation, the leader can be likened to an adult working with **adolescents.**

Self-Directed Team

The leader is no longer central, but is a full and equal team member. His or her role is to *facilitate,* or coach the team; to encourage and help its members to use their abilities to the fullest extent toward achieving the group's and the organization's goals.

Decisions are collaborative, with equal consideration given to each member's ideas. This is how mature **adults** in the larger society normally relate to each other.

What Are The Benefits Of Self-Directed Teams?

When people participate in determining their own goals and methods and are empowered to make other important decisions, they are far more likely to be committed to their jobs and their organization.

They feel that they *own*, rather than merely fill their positions; that what they do can really make a difference. This sense of **job ownership** is at the heart of the concept of self-directed teams.

When empowered individuals are grouped into empowered teams, they can use their diverse experience, knowledge, skills, training and perspectives to accomplish large and important goals.

Like workers in guilds, members of self-directed teams are encouraged to use all their unique talents and knowledge to achieve team objectives. No artificial barriers limit the types of tasks each can do.

This is a dramatic and significant moment in the business world; one that holds promise for major and lasting change.

Unlike bureaucracies, where information flow is limited and much interaction is restricted by protocol, self-directed teams are based on open communication and the free sharing of information.

Because the team structure creates a **"flat organization,"** with few differences in rank, rather than the hierarchical pyramid of a bureaucracy, there tends to be a climate of trust. All members are working for the same goals, and no one succeeds at the expense of someone else.

There is a Japanese term, *kaizen*, which means continuous improvement. This is one of the aims of self-directed teams. The idea is that improvement is not always the result of large, sweeping measures, but often comes from small day-to-day increments.

Self-directed teams are always seeking to refine and perfect each aspect of what they do. Over time, the cumulative impact of those small changes on the larger organization can be very great.

Reports from companies that have used self-directed teams have been overwhelmingly favorable, and a body of research that supports that assessment is beginning to emerge.

Among the benefits attributed to self-directed teams are improvements in these areas:

- **Service And Quality**
- **Cost Reduction**
- **Efficiency And Productivity**
- **Morale And Job Satisfaction**
- **Absenteeism And Turnover Rates**
- **Conflict Resolution**
- **Creativity And Innovation**
- **Employee Adaptability And Flexibility**
- **Utilization Of Employee Abilities**
- **Communication**

A New Paradigm

This is a dramatic and significant moment in the business world; one that holds promise for major and lasting change.

A preponderance of informed opinion maintains that business is undergoing a ***paradigm shift***, of which self-directed teams are a part.

The old paradigm — or model — the bureaucratic organization, which served for the larger part of this century, is considered by many to be unsuitable for today's and tomorrow's businesses. To be successful, they maintain, organizations need to look at themselves in a totally different way.

People today are learning the new paradigm in schools. Increasingly, it is expected that those organizations that don't keep up with the changes will not only miss out on the intrinsic benefits of the new ways, but will have more and more difficulty attracting the best, most knowledgeable workers as well.

Picture yourself in an unfamiliar city. You know where you want to go, and you consult your map to get you there. But no matter how hard you try, you can't find your way. After much frustration, you discover that your map was created in 1900, and that the city has been so altered since then that the map is virtually useless.

Are you using an outdated paradigm?

Future articles on this subject will deal specifically with how self-directed teams can be created and nurtured in the early childhood setting. Techniques for motivating and facilitating teams will be discussed in detail.

Recommended Reading:

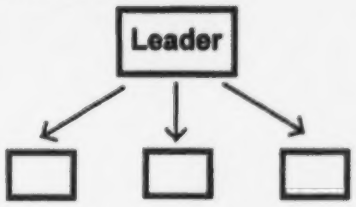
"Empowered Teams," by Richard S. Wellins, William C. Byham and Jeanne M. Wilson, is published by Jossey-Bass Publishers, San Francisco. The book discusses the underlying principles of self-directed teams, gives examples of how businesses have successfully used them, and provides hands-on guidance for creating and maintaining them.

"Zapp! Your Center," an interview with William C. Byham, author of "Zapp! The Lightning of Empowerment" and coauthor of "Empowered Teams," appeared in Issue 203. In it, he discusses the importance of empowerment in the workplace and suggests specific ways to empower child-care staff. For a reprint of the article, send $4 to JCCA; 202 Cirrus Road; Holbrook, NY 11741.

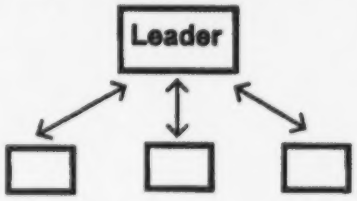
THREE WORKGROUP MODELS

These diagrams illustrate the paths of interaction in three kinds of workgroups:

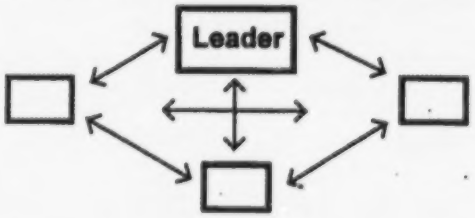
Dependent: The leader **tells** the members what to do. Analogy: Adult and Children



Independent: The leader **guides** individual members. Analogy: Adult and Adolescents



Self-Directed Team: The leader **coaches**, and decisions are collaborative. Analogy: Adults and Adults



COMPARING TWO TYPES OF ORGANIZATIONS

These are some of the key ways that organizations based on self-directed teams differ from bureaucratic, or traditional businesses:

Bureaucratic Organization	Organization With Self-Directed Teams
"Pyramid" Structure Based on Hierarchy	*"Flat" Structure With Few Layers*
Strict Division of Labor	*Team Shares Responsibility for Whole Process*
Explicit Direction From Management	*Team Makes Important Decisions*
Leader (Management) Controls	*Leader Facilitates*
Impersonal Relationships	*Group Cohesiveness Encouraged*
Controlled Information Flow	*Free Sharing of Information*

SPECIAL FEATURE

Mildly Ill Children: What Are Our Options? Part 3: Visiting Established Programs

Parts 1 and 2 of this Special Feature discussed the need of working parents to find care for their mildly ill young children. The problem and possible solutions were viewed from several perspectives. In this part, owners and directors who run center-based sick-care programs share their experience and expertise.

Mixing Sick and Well Children

In Part 1 of this series, which appeared in Issue 212, we presented a view that has recently gained significant momentum among segments of the medical and scientific communities. It is the belief that, because much contagion takes place before symptoms appear, it's safe for children with most mild illnesses to continue to attend their regular child-care programs, among their usual classmates, with no restrictions.

In seeking to interview those who care for sick young children in a variety of settings, the **JCCA** has been unable to locate any centers that currently follow that policy.

Even the **Frank Porter Graham Child Development Center** in Chapel Hill, North Carolina has modified its practice. The center, which is affiliated with the University of North Carolina, was long known as a pioneer in integrating sick and well children. Until several years ago, its policy was to fully integrate all ill children, except those with measles, chickenpox or serious illnesses, with well children in its regular child-care classrooms.

Frederick W. Henderson, M.D., is associated with the center. He is in the department of pediatrics of the University of North Carolina School of Medicine, and as a member of the work group on prevention and control of infectious diseases, participated in creating "National Health and Safety Performance Standards; Guidelines for Out-of-Home Child Care Programs," formerly titled "Caring For Our Children."

The center's very liberal inclusion policy was begun in 1966 when the center opened, according to Dr. Henderson, and ended in approximately 1993.

During that span, the center was participating in a research project studying infectious diseases among children, and had access not only to doctors at the hospital, but to other medical personnel as well. "There was a time when the center had a full-time research nurse practitioner. If a child got sick, the teacher could bring the child to the nurse and be reassured or advised. The nurse was paid for by a research grant. Now, we don't have the capability."

That's not to say that sick children are automatically excluded from care at the center. "Children with mild illnesses; like ear infections or common colds with no fever or very mild elevations of temperature still come regularly." Generally, the guidelines in "National Health and Safety Performance Standards" are followed, he adds.

The lack of centers that fully integrate sick children is no doubt due to several factors — among them state regulations that preclude the practice, and legal concerns. Moreover, many early childhood professionals are not convinced that putting sick and well children together is practical and safe.

Center-Based Programs Are Rare

Not until recently have the need and demand for sick-care programs for young children become so acute as to significantly affect legislation.

While states have long had restrictions — rules specifying when ill children must be removed from group care — few have addressed the issue from the other side and enacted specific regulations for providing sick-child care. Delaware is an exception, and even California, where the concept of ill-child care took hold early and is relatively well established, only recently passed such legislation. Other states are planning to do the same.

Hospitals were among the first to offer care for mildly ill young children. But restrictive legislation, longstanding medical views, scarcity of models to follow, insurance and liability concerns and financial considerations have made sick-child care a rarity in child-care centers.

Nonetheless, such programs do exist, and others can profit from their experience.

First In The Country

According to **Gail D. Gonzalez**, a registered nurse who founded and was the first president of the National Association for Sick Child Day Care, the **Sick Child Care Center** of San Jose, California was the "first formal" center for sick children in the country. It began operating in 1981, and is licensed to serve fifteen children, ages two months to fourteen years.

Gail Gonzalez is health services director of the San Juan Bautista agency, which operates early childhood and after-school programs, including the sick-care program, at ten sites. She is also a consultant.

Grants and Subsidies

The center receives financial help from several sources, including the city of San Jose, the county and United Way. "We also get a rent write-off from our landlord," says Gail Gonzalez. "We pay less than someone normally would, so he's really subsidizing part of the rent."

What Do Parents Pay?

Fees for the Sick Child Care Center are on a sliding scale ranging from $1 to $50 per day, based on family size and income.

San Juan Bautista centers are for families with low income, so parents of children attending them don't pay $50, says Gail Gonzalez, but they don't necessarily pay the minimum either. "It depends on what category they fit. Their category, for example, might be funded by United Way or by the city."

When Are Children Admitted?

Sick children from San Jose and the surrounding areas are permitted to attend the center.

Among the conditions they may have: fever up to 103 degrees, simple diarrhea, cough, stomachache and ear infection and pain. "We operate totally on symptoms. We often see the children long before the doctor does," says Gail Gonzalez. "When the children have a diagnosis — strep throat, for example — and they're on antibiotics, we'll take them. We'll also take them with mildly contagious conditions.

"We give all prescribed medication and treatments. If a child is recovering from a serious illness, we'll give the prescribed physical therapy. We dress or observe wounds. We have a portable machine for breathing, and we can check urine for sugal level. We do whatever the parent would do."

The center can't accommodate those with measles, mumps or chickenpox, because there is no separate ventilation system, she adds.

Medical Consultation

A local pediatrician serves as the center's medical advisor. "Our agreement specifies that we won't call the advisor about an individual child unless it's an emergency," notes Gail Gonzalez. "The child's own pediatrician will fill that role.

"The advisor deals with policy issues. For instance, he gave us a standing order for Tylenol. It specifies dosage according to body weight and fever." Other medication must be ordered by the child's own doctor, by prescription, or for over-the-counter medicine, by phone or written instructions.

Once a year, the advisor goes over the center's policies and procedures and makes any necessary changes.

Admission Procedures

Medical information for children attending regular San Juan Bautista programs is already on file, and others are encouraged to preregister. However, all parents are required to call before bringing in their children. Or the call may come from a teacher if the child became ill while in a classroom.

When a parent calls, a **Screening Checklist** is taken over the phone, according to Gail Gonzalez. Its purpose is to determine whether the child's illness is one that can be accommodated at the center. "We differentiate. We won't accept, for example, just that a child has a cough," but ask further questions about the cough and related symptoms.

On the basis of the checklist, the parent is directed to take one of three actions:

- Bring the child in.
- See a doctor before bringing in the child.
- Find other arrangements because the center can't handle the condition.

On arrival at the center, each child is given a brief physical examination by a registered nurse, who records the information.

Based on the Screening Checklist and the physical examination, a **Care Plan** is devised, with instructions for diet, rest and medication. "The parent has to approve the Care Plan," says Gail Gonzalez. "By signing it, the parent agrees to having the child cared for at the center and to the plan of care the center creates. We tell parents not to sign unless the Care Plan is filled in."

The center also requires the child's immunization records and proof of a complete physical examination and tuberculosis test within the past year.

Recordkeeping

A **Daily Record** is kept for each child. Among its notations:

- What the child ate and drank
- When the child slept
- Periodic review of symptoms
- Temperature at various intervals
- Interactions with other children
- How active the child's play was
- Discharge recommendations ("See a doctor," "Come back tomorrow," etc.)

The center keeps one copy of the Daily Record and gives the other to the parent, with a recommendation that it be shown to the child's doctor.

"If a child can't be comfortable; is hurting and grieving, we'll call the parent to take the child out or to come over to talk with the child."

Gail Gonzalez

Physical Setup

Two main rooms, a "dormitory" for sleeping and a "solarium" — "a playroom set up like a child-care center" — are divided by a small area that holds the children's bathroom, diaper-changing facilities, a washer and dryer and a kitchenette, according to Gail Gonzalez.

The sick-care center shares a common wall with, but has no entrance to a regular San Juan Bautista child-care facility. It has a separate outdoor play area, accessible through sliding doors. "The outside space is a yard with no equipment, because the center has all ages." Small play items — water tables or climbing toys, for example, are sometimes taken outside.

Staffing

A registered nurse, who examines and admits the children and creates their individual care plans, is at the center for half of each day. With him is a teacher's aide.

Daily operations of the center are managed by an early childhood educator. Her assistant is trained in early childhood education and nursing. Other aides have early childhood training. The center makes a practice of having people with nursing and education backgrounds on duty together.

The center maintains an overall staff ratio of 1:3, according to Gail Gonzalez. The "stated ratios" are Infant/Toddler 1:3, Preschool 1:6 and School-age 1:8. "But the youngest age dictates the ratio, and there is almost always an infant or toddler. Seventy percent of our business is infants and toddlers, so we generally have a 1:3 ratio."

Obtaining Insurance

The center has never had problems relating to insurance, says Gail Gonzalez. The general liability coverage for their regular centers was expanded to cover sick-child care.

However, that didn't happen automatically. "When we first applied," she says, "we had very sound practices. For example, we had a manual that laid out all our policies. We didn't just start a sick-care facility. We totally prepared and thought everything out.

"The agent wanted to know our policies. He looked at our manual and showed it to the risk managers and to pediatricians."

Before opening a sick-care facility or trying to insure it, "You have to think through all of the issues."

If Children Can't Adjust

Most children adapt well to the center, but, "If a child can't be comfortable; is hurting and grieving, we'll call the parent to take the child out or to come over to talk with the child."

Final Words

Gail Gonzalez recommends: **If you're planning to offer sick-care, hire a consultant who has had experience in setting up such programs. She adds, "You need to cover all the bases. Have a medical advisor. Follow good, medically sound techniques. Sick-child care is not just an extension of child care."**

A Program That Evolved

Fairfax-San Anselmo Children's Center of Fairfax, California is a regular child-care center licensed for 165 children, from infants through fourth grade. According to director **Stanley Seiderman**, its sick-care program has existed in some form for about twenty years.

"When our 'Get Well Project' began, we used our own staff and resources," he says. "It wasn't good, but parents desperately needed care for their sick children.

"It started with a staff member whose own home was a family day care home. She lived about a block away." After that person was succeeded by another who lived further away, the center participated in a federal program that provided a third such worker, who lived still further from the center. In time, the sick-care program was brought on site. A classroom became a "Get Well Room."

Help From A Local Grant

When the federal assistance ended, "we wanted to continue," Stanley Seiderman says. "It was a good program, and we needed resources. So we reached out into the community for help and got a grant from a community charitable foundation.

"We have to renew it every one or two years. The last grant included other elements of our program and added funds to allow children to attend who don't attend our regular center.

"At this time, we're offering sick-care to selected other nonprofit child-care centers in the county. Ultimately, we plan to open it to people in the larger community.

"The grant provides money for an on-call nurse. The regulations state that when you care for sick children not from your own center, you have to have them checked by a medical professional. So any day an outside child is admitted, the nurse comes in to check the child."

No Insurance Problems

According to Stanley Seiderman, the center has had no trouble obtaining insurance, and has not had to purchase additional insurance to cover its sick-care program.

Physical Setup

The sick-care program, which can serve up to six children a day, is now located in its own building.

It's housed in a portable classroom which is divided into two main sections. One is a sleeping area with two cribs and two cots. The other, larger section, holds a bathroom, shower, sink, changing table, kitchen facilities, resting area with couches, and table-play and office areas. Divisions are created by placement of furniture and equipment.

Staffing

The sick-care program maintains these staff ratios, according to Stanley Seiderman: Infants 1:3, Toddlers 1:4, Preschool or Older 1:6.

Its staff "is composed of two teachers who are also trained in the care of sick children.

"They take classes at local colleges and universities, in CPR, first aid, infectious diseases, procedures in sick-child care, and health education. They also attend local seminars given by area doctors and others.

"Our philosophy is that parents would take care of their sick children at home, and we're doing the same thing here."

Stanley Seiderman

"They're child-care people with special training and skills; not doctors and nurses. Our philosophy is that parents would take care of their sick children at home, and we're doing the same thing here."

The two teachers generally work in shifts, and in addition to their sick-care duties, "they also supplement the rest of the program."

Medical Consultation

"A pediatrician acts as a consultant," Stanley Seiderman says. "We confer with her by phone, or she'll come in for in-house technical assistance or to update policies and procedures."

She receives no pay: "She considers it part of her service to the community."

The center also relies on each child's own pediatrician for specific concerns regarding that child.

When Are Children Admitted?

The program admits children "with almost all of the normal childhood illnesses." Exceptions are undiagnosed rashes, fever over 102 degrees, pinkeye and head lice. "Chickenpox is okay, after it's not contagious. We also admit children who are recuperating from broken bones."

And, adds Stanley Seiderman, "We have had children who aren't sick but claim they are. They want to stay there and relax. We don't encourage it, but we don't discourage it if it's once in awhile."

What Do Parents Pay?

For children who attend the regular center, there's no extra cost. Those from other centers pay $35 per day.

Is the cost a problem? "Yes. Some parents need help from an outside source. Our hope is that businesses will provide sponsorship; that they'll purchase slots for their own employees as well as others in need. It's the businesses that benefit. Their workers can stay at work."

Admission Procedures

For each sick child from another center, the program requires emergency and immunization forms, plus an information sheet filled out by the child's pediatrician. The emergency and physician forms were created with the help of medical consultants, and are "fairly simple," Stanley Seiderman says, and the immunization form is from the state.

Prescription medication must be properly labeled. For both prescription and over-the-counter medications, a parent is required to fill out a form providing specific written directions.

Recordkeeping

The center has "a fairly detailed system" of logging children in, noting their daily progress and documenting administration of medicine. For its future use, it also keeps statistical records noting number and ages of children served and basic symptoms.

Parents aren't provided with written records, but are encouraged to call during the day or speak with staff when picking up their children.

Final Words

Stanley Seiderman's advice to others who are thinking of providing sick-care: **"Do it. You cannot believe how important this service is to families. I don't think parents and people in our profession know how easy it is to do. It's a very valuable service."**

In Part 4 of this Special Feature, we'll interview those who run sick-care centers in three different categories: freestanding nonprofit, center-affiliated and freestanding for-profit.

For more information, contact:

Dr. Frederick W. Henderson
Department of Pediatrics
University of North Carolina School of Medicine
Campus Box 7220
Chapel Hill, NC 27599
(919) 966-7160

Gail D. Gonzalez
Sick Child Care Center
1945 Terilyn Avenue
San Jose, CA 95122
(408) 272-7425
For information about her sick-care consulting services: (408) 779-4753

Stanley Seiderman
Fairfax-San Anselmo Children's Center
199 Porteous Avenue
Fairfax, CA 94930
(415) 454-1811

NOTICE TO OUR READERS

Please write to me if:

- ***You have something to share with other owners and directors.***
- ***You have additional insight or information relating to an article.***
- ***A JCCA article has been particularly helpful to you.***

Thank You

Christine Kalbaugh, Editor

Productive Parent Meetings: Interview With Dr. Suzanne M. Foster

Suzanne M. Foster, Ed.D., is an assistant professor of elementary and early childhood education at Anderson University in Anderson, Indiana.

Previously, she was the director of a child-care center licensed for 200 children. She is also a former public elementary school teacher and reading specialist.

We spoke with her recently about planning and holding meetings that will attract and benefit parents and strengthen their bonds with the center.

Q Why should a center hold parent meetings?

A The main reason is to continue to involve parents in the center. Children can spend up to ten hours there. Parents can feel as if they're part of their children's lives; are sharing in their experience.

Q Should children be allowed to attend?

A Yes. Parents are more likely to come if you let them bring their children.

Provide babysitting for the younger ones, but it has to be free. Staff members may agree to babysit, or you can hire college students. You may be able to reserve a room for it, or you can find other space. It depends on your center's setup.

If you have babysitting, you have to provide activities and snacks. You need a sign-up sheet, so you know how many babysitters are needed and what you have to have on hand.

Q What else may motivate tired parents to come?

A People today are exhausted. But anything that children do, parents will go to.

A good idea is a parent/child activity night. You can have a speaker for the whole group, and then the parents and children go to different rooms for different activities.

The parents can see what their children do at school. Then they won't ask for worksheets and other inappropriate things. They'll gain an understanding of why things are done in developmentally appropriate ways.

Another idea is to have a dinner meeting. The center can provide sloppy joes or another inexpensive main dish. The parents can be asked to donate $1 each, and to bring in desserts, and even their own utensils and plates. It doesn't have to be expensive.

The advantage, besides that the parents don't have to make dinner, is that it can be held at closing time. People won't have to go home and then come back to the center.

Lead teachers should attend the meetings. Parents will want to speak with them.

You have to support meetings with day-to-day communication with parents and a weekly newsletter. That's critical. They need to know what's going on in the center.

If you communicate on a regular basis through your newsletter and informal conversations when they pick up their children, parents are more likely to come to meetings. What's needed is bonding.

Finally, don't approach topics with the attitude of, "We're the experts." That's offensive to parents. You'll get a higher percentage if you consider it sharing and ask for and respect the parents' viewpoints.

Q How many center-wide parent meetings do you recommend for a year?

A Three or four per year are the most you're likely to get them to attend. For the rest of the time, fill in with newsletters and informal conversing with parents.

Q What plans make a parent meeting successful?

A I recommend:

Set a purpose. Why are you having the meeting? You don't want unnecessary meetings.

You can survey parents for topics with a questionnaire. List some choices and leave spaces for their suggestions. That way, they gain ownership in the process.

The key is asking parents for input. If you do, they're more likely to attend.

Schedule. You can also ask parents what times are most convenient for them, but it's usually too difficult to accommodate everyone. Their schedules are too diverse.

Use the questionnaire to choose topics for the three or four meetings to be held during the year. Put them on a master calendar with the dates and times, and send it home.

Involve parent volunteers in helping to plan. If you can't get them, staff members can divide up the jobs. The director is too busy and should delegate these tasks. It's a good way to involve the staff in decisions.

Even one person can do the planning, but two or more are better.

One major decision is how the topic will be presented. Among the choices are a lecture by center personnel or an outside speaker, a video, a panel discussion and an open discussion.

Q What are some "hot" parent meeting topics?

A Some I've found to be popular are:

Discipline: It's extremely important to present this as an opportunity for sharing. Don't approach it as, "We're right; you're wrong."

That's not to say that you don't inform the parents, but you have to be careful. You might say, for instance, "These are ways we use to discipline." Or, "Here's what current research tells us."

There are cultures, for example, that spank children. Present your point of view as an alternative; more as sharing without shaming. These are the people you want coming back. You want to be able to model your ways of interacting with children for them.

If you want parents to trust you, you have to respect them.

Developmentally Appropriate Practice: I went to a great meeting on this recently. They had parents do examples of both appropriate and inappropriate activities.

Getting Ready for Public School: Will preschool prepare them? Will the developmentally appropriate practice enable them to succeed in the more structured public schools? "Will my child be behind?" "Do I need to teach my child to read?"

Age-appropriate Behavior: "Is my child okay?"

Gifted Children: This is popular, but is being displaced by the idea of multiple intelligences.

Multiple Intelligences: This is a *great* parent topic.

Q What elements make a good parent meeting?

A A good meeting is short and sweet. It should take no more than an hour for everything, including the refreshments.

Children have a short attention span, and so do tired adults. Remember that they probably have to go home after the meeting and give baths and do other chores.

I think it's best to have the refreshments set out, for people to take whenever they want them.

This is the basic format I use and recommend for meetings:

1. **Icebreaker:** One I like is to pass around a tray of candy. While taking a piece, each person tells the group something about himself or herself. The person running the meeting starts it off by doing it.
2. **Brief Introduction:** State the purpose of the meeting. For example, "We're here to share ideas about discipline."
3. **Sharing:** If you establish the climate correctly and get them talking, they develop rapport with each other and will share more. If you don't acknowledge that they know something, they won't listen.

   You might want to start with everyone together, break into small discussion groups, and then come back together to share what was said in the groups.

   The presenter officially ends the meeting with a summary statement.
4. **Handouts:** Parents like to take home something from the meeting. Handouts can summarize key ideas, list further sources for exploring the subject or suggest related activities for parents to do with their children.

You can also distribute notices with information about the next meeting.

5. **Evaluation:** Ask parents to fill out a questionnaire asking what they thought of various aspects of the meeting.
6. **Analysis:** The planning committee and others involved in the meeting should get together and use the parent questionnaires and their own evaluations to analyze the meeting. Strengths and weaknesses should be discussed and what is learned applied to the next meeting.

Q What would you like to add?

A You might want to consider possible alternative sites. All meetings don't have to be at the center.

When parents have negative feelings about school, it sometimes even filters down to the child-care center. They may be more comfortable elsewhere.

If you sense that many of your parents feel that way, you may consider, for example, a local church or community center that can be used free of charge.

And here's a great idea someone recently shared with me: Videotape parent meetings and send the tapes home to the parents who didn't attend.

For more information, contact:

Dr. Suzanne M. Foster
School of Education
Anderson University
Anderson, IN 46012
(765) 641-4403

I Am Your Child

A National Campaign

The national *I Am Your Child* campaign is dedicated to making early childhood development a top priority for America.

Actor and director Rob Reiner, the campaign chair, leads a coalition of organizations and individuals from various fields. Their objective is to unite the efforts being made across the country to involve families and communities in the healthy development of young children.

The campaign officially began on April 16, 1997, and the next day Rob Reiner and other campaign leaders participated in the first **White House Conference on Early Childhood Development and Learning.**

At that conference, scientists presented information on **breakthrough research** showing that **experiences during the first years of life directly affect how a baby's brain grows.** They help to determine the brain's structure, and profoundly influence how the child will learn and behave throughout life.

The Spotlight Is On You

These dramatic new insights and the national publicity they are gaining through *I Am Your Child* offer owners and directors of early childhood facilities an unprecedented opportunity to make their needs widely known.

It's a chance to stress that professional child care is a crucial service that has been vastly undervalued in our society. The research provides a strong scientific "hook" to get the attention of the American public; to point out what should be, but at this point is not, a universally accepted logical progression:

1. **The first years of life have a critical, permanent influence on how young children will develop.**
2. **Great and increasing numbers of young children are spending large segments of those formative years being cared for outside of the home, by adults other than their parents.**
3. **Using our resources to do whatever we can to strengthen that care is crucial to the nation's future.**

Getting Involved

There are many ways to apply America's resources to early childhood development. To begin with, we need a **strong foundation** to support our efforts. That calls us to develop and advocate **public policies** that reduce poverty, inadequate nutrition, neglect, abuse and other major risks to young children and their development.

And we need **more direct ways** to champion and improve professional child care, including financial and other assistance with caregiver training, strong parent involvement in programs, and strategies for making quality child care affordable to all parents who need it.

Continued on page 14

How to add your voice to this crusade is an individual decision. The **JCCA** will continue to present information on *I Am Your Child.*

For more information, contact:

"I Am Your Child" Campaign
1010 Wisconsin Avenue NW
Suite 800
Washington, DC 20007
(202) 338-4385
Website: www.iamyourchild.org

For parents in your program: The campaign offers a free booklet, "The First Years Last Forever." Call (888) 447-3400.

CPR Training System

A recently developed product, designed to provide instruction and practice in CPR and choking first aid skills, could be used for training your staff or teaching lifesaving techniques to parents of children in your program.

The main components of the **CPR Prompt Home Learning System,** manufactured by County Line Limited, are a video, a supplemental booklet, an infant manikin and an adult/child manikin.

The product is approved by the American Heart Association, and its instruction is based on that organization's guidelines.

The **video** demonstrates, using the system's manikins, how to perform the lifesaving techniques on infants, children and adults. The viewer is prompted to duplicate each on-screen step, and is encouraged to pause the video while perfecting each skill.

Hearts displayed on the video screen are color-coded for each age group and numbered according to the skill — CPR and Rescue Breathing, Choking-Unconscious or Choking-Conscious — being taught in that segment. The coding allows the viewer to quickly locate the age group and rescue procedure desired by fast-forwarding or rewinding. There is a review at the end of each age-group section.

The 43-page **Supplemental Learning Guide** follows the same basic format as the video, with corresponding coded hearts. It illustrates the steps of each procedure with text and drawings in a clear, uncluttered layout.

The section for each age group has:

- Skills Overview
- Assessment Steps
- Rescue Procedures
- Practice Exercise

The booklet also provides additional information about CPR and choking first aid. An eight-page auxiliary section addresses special emergency situations, commonly asked questions about the rescue procedures, early heart attack and stroke warnings and recommended action, advice for lowering risk of heart attack, and suggestions for protecting infants and children from injury.

The **manikins** — very sturdy, dishwasher-safe heads that snap into chests of commercial-grade foam — are used with disposable lung bags. The larger manikin has a dial to select the adult or child (ages one to eight) setting.

Manikins have anatomical markings — Adam's apple, neck grooves, chest notch, nipples, rib cage, navel, shoulder blades — to help with the learning of key hand positions for each rescue procedure.

They also provide feedback to indicate whether skills are correctly performed. If a person breathes into a manikin's mouth, the chest visibly rises, but only if the head is properly positioned and air correctly routed. The adult/child chest clicks when pressed in the right place and to the right depth, and a solid plate in the infant manikin chest stops the hand to indicate correct position.

The original box can be used for storage of system components.

The company also manufactures an auxiliary product, the **CPR Prompt Rescue and Practice Aid,** a hand-held, battery-powered device that "talks" trained rescuers through the steps of each of the lifesaving procedures. Designed to provide a quick review of skills or to serve as a "coach" during practice or an actual emergency, it has a practice reminder light that flashes every forty-five days.

A 1996 issue of "Currents in Emergency Cardiac Care," an official publication of the American Heart Association and the Citizen CPR Foundation, notes: **"Although the Home Learning System can be a sole source of CPR learning for a layperson, the AHA considers both products complementary to the CPR training network."** They are not

intended to replace standard courses for child-care and other professionals, and no official credentials of any kind are conferred through them.

County Line Limited has a toll-free phone number and an e-mail address for answering users' questions about the materials or the course.

Rick Carpenter, the company's vice president of marketing, says, "The biggest opportunity I see in child-care centers is to use our system as a means to ensure that parents know CPR. The center can tell them, 'Seventy percent of these emergencies happen in your home.'

"People need to have at least some sense of CPR. The problem with relying on 911 is that four to six minutes can mean brain damage or death. You call 911, but do CPR in the interim, or the whole system breaks down.

"The facts are that only one-third of the population has learned CPR even one time, and retention of the skills is a big issue."

What if a center is able to offer a basic training session for parents, but can't follow up with additional sessions for them to perfect their skills? "If you had a chart on CPR inside of your cabinet, and followed it to perform CPR, it would be better than no CPR. Doing something is better than doing nothing."

For more information, contact:

Rick Carpenter
County Line Limited
4543 Taylor Lane
Warrensville Heights, OH 44128
(800) 667-3541

Call the company for information on how to purchase the Home Learning System (approximately $60) and Rescue and Practice Aid (approximately $100) by mail. They are also available in stores and sold by many AHA instructors.

Free Health and Safety Guide

JCCA Issue 204 informed readers about "Caring for Our Children."

The book, retitled **"National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs"** (formerly the subtitle), is currently available free of charge.

Originally published in 1992, it was the product of four years of collaboration by the **American Public Health Association** and the **American Academy of Pediatrics**. It was funded by the **Bureau of Maternal and Child Health** of the US Department of Health and Human Services.

Intended as a comprehensive health and safety guide for those who care for children, it is also designed to be a model for licensing requirements, so the standards are written to be measurable and enforceable.

Approximately 150 health and child-care experts from all parts of the country contributed their expertise to the book.

Before publication, it was submitted for a nationwide review by 2500 individuals and organizations representative of its intended users — child-care administrators, caregivers, health consultants and consumers, and state licensing regulators. Their comments were solicited and considered. There was also a field assessment by 400 people over a multi-state area.

The book, which has 322 pages of text, plus appendixes, an index and a glossary, is considered a definitive reference source.

Chapter headings are:

- **Staffing**
- **Activities for Healthy Development**
- **Health Protection and Health Promotion**
- **Nutrition and Food Service**
- **Facilities, Supplies, Equipment, and Transportation**
- **Infectious Diseases**
- **Children With Special Needs**
- **Administration**
- **Recommendations for Licensing and Community Action**

For more information, contact:

National Maternal & Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182-2536
(703) 821-8955, Ext. 254

To order: (703) 356-1964; Fax: (703) 821-2098

The full text of this book may be downloaded from the website of the National Resource Center for Health & Safety in Child Care: **http://nrc.uchsc.edu**

Book on Building Enrollment

"101 Ways To Build Enrollment In Your Early Childhood Program," by **Ellen Orton Montanari,** delivers more than it promises. It actually offers 112 well-conceived, practical ideas.

Ellen Orton Montanari is principal of The Creative Planning Group, a business consulting firm in San Marcos, California and Phoenix, Arizona. She has an MBA and a degree in early childhood. In addition to her consulting work, she does public speaking on the subject of child-care administration.

She says, **"One reason I wrote the book is because the average person running a center can't afford to have someone come in to teach these techniques."**

The book's concise, easy-to-read format is supported by sound business concepts, she adds. **"Owners and directors don't have time to read a theory book, so I had to interweave the theory. Each hint has a solid theoretical underpinning."**

The 166-page book has five chapters.

- **GETTING STARTED** deals with putting basics into place and includes logos, brochures, business cards, enrollment packets, stationery, flyers and mailing lists.
- **PROMOTING YOUR PROGRAM** covers ideas organized under *Community Marketing, Advertising, Publicity* and *Referrals.*
- **THE ENROLLMENT PROCESS** *includes Telephone Tips* and *The Enrollment Visit*
- **ONCE THEY'RE ENROLLED** deals *with A Child's First Days* and *Keeping Current Families Happy*
- **PUTTING IT ALL TOGETHER: DEVELOPING AN ACTION PLAN** is a step-by-step guide for ensuring that your time and money will be wisely invested.

Ordering Information:

This book may be purchased for $12.95 plus $3 for shipping from:

CPG Publishing Company
PO Box 50062
Phoenix, AZ 85076
(800) 578-5549

Here is a sampling of hints from "101 Ways To Build Enrollment In Your Early Childhood Program," by Ellen Orton Montanari:

Getting Started

"Your exterior signs must reflect the same theme as any advertising or printed material about your center. Your sign should use the same colors as your logo. Your logo should also appear on the sign."

Promoting Your Program

"Secretaries and receptionists in local elementary schools greatly influence parents' child care choices." Parents often ask them about both preschool and after-school child care. Make it a point to keep in touch with them on a regular basis.

One specific suggestion: "Every August, take a handful of pencils with your program's name, address and phone number engraved on them to school receptionists. Your center's name is never far from their fingertips!"

The Enrollment Process

"Always follow up with a note after a parent has visited your program."

One tip on making your message effective: "Personalize the letter by mentioning the child's name. Also refer to something about the family's needs that you learned. For example, 'I know how hard it is to find part-time care for Jonathan.' "

Once They're Enrolled

"On a child's first day in your program, take a Polaroid picture of the child involved in an indoor or outdoor activity. Put it in a cardboard frame that says, 'My First Day at ABC Preschool.' "

Mail it to the parent's workplace, with a letter of thanks for choosing your center. The parent is likely to keep the picture at work, giving your center added exposure.

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JOURNAL OF CHILD-CARE ADMINISTRATION
Issue 215
A National Publication Addressing The Concerns Of:
Child-care Centers Learning Centers Preschools Nursery Schools Kindergartens Intergenerational Centers

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Creating And Building A Scholarship Fund

Judith Cooper is executive director and Linda Schatz is director of finance of Play & Learn Centers in Pennsylvania.

The ten Play & Learn Centers are nonprofit. Most are licensed for ages six weeks to six years and serve from seventy to ninety children. The first center opened in 1981.

We spoke with Judith and Linda about the company's "Granny Fund," which assists parents with tuition fees, and about its biggest fundraising event, the Spring Fair.

Q You serve mostly middle-income families. Do many need help with tuition?

A Not many, but some families do need assistance at times.

There can be various reasons. Maybe there is temporary lack of employment. Or reduced employment — seasonal workers like landscapers, gardeners and roofers may have less work, for example. People may become ill or temporarily disabled.

Sometimes a family is eligible for subsidized care from the county or other government agency but is on a waiting list. We offer them a scholarship until they can get the subsidy.

Q Why do you call it your "Granny Fund?"

A It's to honor grandparents.

Most people have giving, kind grandparents who want to help them. A grandparent is representative of someone who cares about those in need.

We're in a field of caring. We want to help people.

Q How do you raise scholarship money?

A We use various fundraising methods, but our biggest event is the annual Spring Fair, in which all of our centers participate. We've been doing it for nine years.

Q Where do you hold your Spring Fair?

A We hold it in Fort Washington, where two of our centers are located.

We have property adjacent to a private academic school. We combine the parking and green areas of the two schools.

Q Can a fair be held in limited space?

A The fair itself can be in a rather compact area.

The biggest issue is parking. We'd advise borrowing parking space from another business or having the fair at a park.

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Q Do you charge admission?

A No. Money is collected through the sale of tickets for the various activities.

We have a ticket table near the entrance to the fair. Each ticket costs fifty cents, but discount vouchers are sold in advance at the centers. They can get a voucher to purchase six tickets for the price of five.

Q What are some booths at your fair?

A Each center has its own booth.

Among those we usually have are face painting, bean bag toss, water-soluble "tattoos," miniature go-carts, fishing for toys, and arts and crafts.

The games are designed for children up to about age six. Most booths charge two or three tickets for playing a game.

Q Where do you get the prizes?

A They are donated.

We solicit our vendors, parents and local stores, asking them to donate stuffed animals and other prizes.

Q Do only centers have booths?

A We also invite craft-type vendors to set up tables for a fee.

Q How much should vendors be charged?

A The amount depends on the community. You might charge fifteen dollars, for instance.

Q Do you have rides?

A Yes. We hire professionals who run their own rides. We have pony rides, a "moon bounce," a little ferris wheel and other carnival-type rides.

Most of the rides cost about six tickets. The professionals collect the tickets. At the end, they turn them in to us. They get eighty percent of the money taken in and we get twenty percent.

Q Do you sell food?

A Yes. As with the rides, we hire professionals for that, and we advise other centers to do the same.

Try to find vendors who will do it on a contingency basis, giving the center a percentage of what is sold. You get more of a guarantee.

We used to cook our own funnel cakes and hot dogs, for example. But you may buy too much and reduce your profit.

Try to get the biggest percentage you can from each vendor. Even better is to get donated food and drinks. Get everything you can donated.

Q What else does your fair offer?

A We try to get as much entertainment as possible.

Q How much do you pay entertainers?

A We don't pay them.

We try to get volunteers who want to perform at children's parties, like clowns, people with animals, and guitar players and other musicians. They're willing to work for free at the fair for the exposure.

Many people we hire through the year — those who go to different centers to do musical activities, for example — also will perform at the fair without charge.

Q Do you pay staff to participate?

A No. They donate their time.

Q Does anyone object to the extra time?

A No. The staff handbook states that it's expected. But it's a fun day for them.

Some people can't come for a valid reason — there may be a wedding, for example. Others can attend for part of the time.

The main idea is to you have to get coverage of all the stands.

Q What are the days and hours of the fair?

A It's usually held on a Saturday from ten o'clock to three. We have the fair rain or shine because we found we couldn't get commitments from staff and volunteers for two days. We've had rain, but we've never had to cancel.

If you're concerned about rain, you may try to combine indoor and outdoor activities, using a gymnasium or auditorium.

Q Where do you get the setup materials?

A The centers make their own stands. They're not elaborate. We don't spend much on setup. And we save some materials, like the bean bag toss frames and signage, from year to year.

Q How much planning time is required?

A We don't need very much time.

Each center director gathers ideas by walking around and holding small meetings. Most of the planning is by direct communication.

We've been doing this for so long that these things are almost on automatic. The director may just ask, "Do we want to do something different this year?"

Central administration makes sure that all the stands are covered. We coordinate marketing, signage, external donations and promotion.

Q How is the fair promoted?

A We list it in the local newspaper's "Calendar of Events."

We also notify the community through flyers to parents, and we send reminders in newsletters.

About three weeks before the fair, we put up a sign at the site, giving the date and time.

Q Are on-site events the only way for a fair to earn money?

A Absolutely not.

We would advise a center, "Reach out to all your vendors." Try to get donations from those who provide insurance, health care, computers, computer repairs, and supplies. Ask your attorney and accountant, your landlord — anyone who has a business relationship with the center.

We put together a letter that explains what the monies will be used for and makes recommendations for amounts. We've received from $25 to $1000. These are the categories we created:

- Granny Friend: Up to $250
- Bronze Donor: $250 to $500
- Silver Donor: $500 to $750
- Platinum Donor: $1000 or more

We promote each company that donates a large amount by putting up a banner at the fair thanking them. We also print a Spring Fair program and list all donors in it.

Q Do the programs carry advertising?

A Yes. We charge each local business $10 to copy its business card and print it in the program. This is very successful.

Each center sends someone in person to solicit businesses in the community.

Q How do you distribute programs?

A We put them in the children's cubbies and have them available at the entrance to the fair.

Q How else do you raise money for your "Granny Fund?"

A We have candy sales, school photos, Santa photos and other events.

Q How do parents get scholarship money?

A A parent has to fill out a scholarship application form and provide a tax return, two recent pay stubs or other documentation to back it up.

We match the income against the amount that qualifies a familly for a subsidy, taking dependents into account.

Q What are the terms of the scholarship?

A The highest reduction we give is twenty-five percent of the tuition. Others get discounts of twenty, fifteen or ten percent.

Generally, the scholarship period is limited to three months, unless the family is eligible for a subsidy and is on a waiting list. In that case, we provide the scholarship until the subsidy comes through.

Q Is repayment ever required?

A Never.

Q What other guidance can you offer?

A We would caution that you need to establish a starting fund you can have confidence in before you start to distribute the money.

In the first year, you may disburse only a small amount. You want to continue to have enough money to maintain the fund.

Don't be discouraged by the smallness of your start. You can always add other activities to build your fund.

For more information, contact:

Judith Cooper or Linda Schatz
Play & Learn Centers
200 Camp Hill Road
Fort Washington, PA 19034
(215) 643-4142

SPECIAL FEATURE

Mildly Ill Children: What Are Our Options? Part 4: Three Varied Sick-Care Programs

In this final part, the JCCA interviews people involved in running three different kinds of sick-care centers.

First In Oklahoma

Bearly Sick, of Tulsa, Oklahoma, is that state's first and only licensed freestanding child-care facility for sick children, says director **Tamie L. Schrimshaw**. It opened in mid-1997, and is licensed to serve seventy-five children, ages six weeks to sixteen years.

Tamie Schrimshaw, who has been in the nursing field since 1980, was chosen by the National Association for Sick Child Day Care to chair its first national conference in September 1997. She is currently serving on a state commission to develop sick-care licensing regulations for Oklahoma.

"The states with the most sick-care facilities," she says, "are California, Alabama, Florida and Indiana, but many others are beginning to work toward them."

Seeking Financial Help

Bearly Sick is a nonprofit organization. That, says Tamie Schrimshaw, has been a huge benefit.

Money and materials have come to Bearly Sick through various means, including an equipment grant from a local charitable foundation, matching and other grants from local and out-of-state companies, and a silent auction the center holds each year.

In the continuous search for funding, **"Creative is the key word,"** Tamie Schrimshaw says. **"When we bought our building, we got everything donated from local companies to fix it up.** We needed dry walls, so I called a company and asked them to donate the labor. I called another company and asked them to donate the materials. I involved the local builders and contractors association. Even utility companies can help; ours waived our deposits."

Beyond the tax credit they received, those donating expected nothing in return, she adds. **"They considered it a community service."**

What Do Parents Pay?

The cost for each child is $5 per hour, with a four-hour minimum. There is also a one-time $20 registration fee. In the future, says Tamie Schrimshaw, **"I'd like to set up a foundation so we can put those who can't pay the full amount on a sliding scale.** We're looking at ways to make it affordable to parents."

When Are Children Admitted?

Sick children from Tulsa and the surrounding areas may attend. However, the center doesn't allow those with chickenpox, measles, mumps, rubella, scabies and lice, or other conditions that are spread through the air, as those require a separate ventilation system. "We may do that in a second facility," says Tamie.

Are There Insurance Problems?

"I had trouble finding a company that would sell us insurance," she says. "We didn't fit into either a hospital or a child-care category.

"Basically, they had to underwrite us individually. **We probably pay more than a regular child-care center would, but it's less than I thought we'd have to pay.** I thought it would be prohibitive."

Physical Setup

The center's site was chosen because **"it's in a central place convenient for working parents,"** says Tamie Schrimshaw.

Children are grouped according to age and illness among four rooms.

The **nursery room** has eight bassinets set up along the periphery, with the middle used as a play area. The **infant room** has six cribs and is set up the same way.

The **toddler room,** the largest, has fifteen toddler beds around the periphery and play tables and chairs in the center. "It's very versatile," says Tamie Schrimshaw. "We use portable room dividers to divide it as needed. If three children have diarrhea, for instance, their area can be isolated, with their beds and their own play table. We can move things around, but we have to be sure not to block the exits. Our code requires that each room has an exit to the outside."

"I highly recommend using student doctors and nurses. They're very diligent and dependable. It's a wonderful resource."

Tamie Schrimshaw

The **older children's room,** for ages six to sixteen, has ten twin-size and toddler beds along the walls and an activity area in the center.

Additional bassinets, cribs and beds are on hand, for use as needed.

What Activities Are Offered?

Children play with age-appropriate toys, including art materials, writing boards and a table tennis set. **"We gear activities to whatever each child wants to do.** Some want to be held all day, and some don't want to be touched. Each child decides whether or not to stay in bed.

"Toddlers take two naps a day, or they follow the napping routine they're used to in their usual child-care center. We work with each child to provide what he or she needs."

The center has VCRs on carts that can be rolled into children's rooms. Some videos are kept on hand, and the children are permitted to bring their own. Only **family-oriented** cartoons or movies are allowed, and the **staff reviews all videos** before they're shown.

In an agreement with a nearby hospital, students training to be child life specialists entertain the children with puppet shows and other activities, on a volunteer basis.

Staffing

Tamie Schrimshaw or an assistant is on site to administer the facility all day, and a pediatric registered nurse is there as well.

In addition, the center has agreements that allow it to use student nurses and doctors as volunteers. **The students get necessary experience, and the center benefits from their checkups and other services.**

"I highly recommend using student doctors and nurses," says Tamie Schrimshaw. "They're very diligent and dependable. It's a wonderful resource.

"Student nurses need a place to learn on mildly ill children. When children are seriously ill, they can't be disturbed" to frequently have their temperatures taken, or for other routine practices.

"Doctors usually don't do pediatric rounds until the third or fourth year. They need practice. We have student physicians **on call twenty-four hours a day.** One is assigned every day full-time to the center. They're on call, and they're right down the street. If we need them, they'll come. **If a child had an undiagnosed rash, for example, we'd call and a pediatric student would come to diagnose it."**

The center maintains the following ratios, according to Tamie Schrimshaw: Infants 1:4, Toddlers 1:6, Preschool 1:8 and older children 1:10 or 1:12, depending on their ages.

Admission Procedures

The center encourages preregistration, but requires that parents call before taking their children in, even if they're already registered.

The preregistration form calls for basic information about the child, such as medical history, allergies and emergency numbers.

Every day, the parent is required to fill out a permission form for the child to stay at the center and be treated. It notes medication and dosage, and when it is to be administered. A very important entry, says Tamie Schrimshaw, is "Time Last Given," which assures continuity of care. **The parent and a staff member both sign and date the form.**

Recordkeeping

For each child, the center keeps a **daily activity**

sheet noting medical information such as when medication was given, what the child ate and what the temperature was at various intervals. At the end of the day, a staff member goes over the activity sheet with the parent. **The parent takes one copy home and a copy is kept at the center.**

Closing Words

Tamie Schrimshaw advises those who want to provide care for ill children: **"Keep trying. It can be very frustrating. It's difficult because very few others have done it. You're on your own. There are always difficulties when you're doing something new."**

First In New York

Sniffles, of Albany, New York, is believed to have been that state's first center for the care of mildly ill children. Begun in 1990, it is affiliated with the Riverview Day Care Center, but is located at a separate site.

According to director **Barbara Smith**, a registered nurse, Sniffles is equipped to care for ten children. It isn't licensed, she adds, because although New York is planning future regulations, it doesn't currently license sick-care facilities.

Do Grants Help?

The nonprofit center is run without grants, according to the director.

Tuition

The center, which is open to all sick children in the area, charges $6 an hour, plus a one-time $25 registration fee, Barbara Smith says.

Is that too much for some? Yes. "Many people complain." The center would like to find ways to help single parents and others who can't afford those fees. But, "Most people who use our services are from two-income families. Some are doctors, lawyers and (as the center in located in the state capital) government workers."

Guidelines For Admitting

"We don't take children with fever over 104 degrees, or with contagious diarrhea, or when they're initially post-operative."

Among the conditions that are accepted: mild colds, ear infections, strep throat, flu and chickenpox.

Admission Routines

Preregistration is offered. To ensure that the center is prepared to take their children, parents are instructed to call before coming in.

An admittance form records the child's health history, parent information, physician, immunization records, behavior related to illness and other basic data.

Records

Barbara Smith reviews with each parent the day's plan for administering medication to the child. The parent then signs a medical release form.

At the end of the day, the parent gets an assessment sheet with information about the child's condition and activities, and a medication report.

The center keeps a data sheet that lists children, when they attended and what conditions they had.

Setup

The children are divided first according to illness, and then by age, Barbara Smith says. They are placed among six rooms, with no more than two children in each. From her centrally located office, she can observe all of the rooms. The center has a special ventilation system.

"They're often afraid at first, but after the first day they want to come back."

Barbara Smith

Activities

Age-appropriate toys and materials, including trucks, dolls, blocks, doctor kits, farm toys and a doll house are available for the children.

A VCR can be brought to the children's rooms. The center has videos, and the children can bring others from home.

Staff

Barbara Smith is at the center at all times. Child-care workers are on call as needed. Minimally, a 1:4 ratio is maintained, but "that's adjusted if necessary. For example, **if we have two infants, and one wants to be held all the time, I call someone."**

Do The Children Adjust?

How do the children react to being in an unfamiliar

environment when they're sick? "They're often afraid at first, but after the first day they want to come back."

Do Emergencies Occur?

"I find that most parents of children who are very, very ill stay home to take care of them. Most parents seem to be very responsible about that.

"Once in awhile, we need to call a parent because a child has a high fever or another serious symptom, and advise that the child be taken to a doctor."

Final Words

Barbara Smith warns those thinking of starting sick-care centers to be aware of one challenge inherent in the venture: **"Certain times of the year tend to be very busy, and other times very slow. The center has to be available regardless of the demand."**

A For-Profit Stand-Alone

Feeling Better, of Sunnyvale, California, is a free-standing, for-profit sick-care center licensed to serve thirty-three children, ages three months to thirteen years. It opened in 1989.

Financial Structure

According to office manager **Diane P. Parker,** the center's contracts with local companies are instrumental to its financial success. They were developed through experience, she adds.

"Originally, we were funded by **venture capitalists.** We went to employers and told them the daily rate, which at that time was $40. We asked whether they would pick up part of it for their employees. Generally, the employees paid 25 percent — $10 a day. At the end of the month, we'd bill the companies for the rest.

"It didn't work out. There was a big drop in the summer months," so the center couldn't make enough money under that plan.

After about a year, "We went to **'Plan B.'** We now charge each company a basic amount each month. That entitles its employees to unlimited usage of the center. The flat fee is based on the company's overall population. It ranges from $200 to several thousand dollars per month.

"The premise is that when the employers pay, they save an incredible amount of money" because they can maintain productivity without replacing employees while their children are sick, or risking lowered morale because those on the job have to work harder to make up for the absent ones.

"It's an easy benefit to add. It's work-family friendly. The companies in our area are competitive. They want to provide good benefits.

"We currently have agreements with about two dozen companies; some large, some small." The agreements include the stipulation that in the event that the center has to turn away children, parents from participating companies have priority over those from other sources.

Cost To Parents

The center's regular fee is $55 per day.

Some participating companies subsidize 100 percent of their employees' costs, and others pay a portion. Typically, parents with partially subsidized fees pay from $10 to $15 per day.

Employer-subsidized attendance, either full or partial, accounts for 75 to 80 percent of the center's business, according to Diane Parker.

Are most of the parents who pay the full $55 able to do so easily? "It's more that they feel they have no alternative. We're trying to get more companies to subsidize. The parents want that."

When May Children Attend?

The center accommodates most mildly ill children, but because it has no separate ventilation system, it doesn't admit those with chickenpox, mumps, measles, head lice or several other conditions that can be spread through the air, according to Diane Parker.

Physical Design

The center has an open appearance, she says, **and is divided into two main areas.** One, for ages three months to two years, has cribs, high chairs, diaper-changing facilities and play space.

The older children's area has two rooms with bunk beds. Children are assigned to the rooms according to illness category. Each child chooses a bunk bed for the day. Those younger than six get the bottom beds.

The older children can rest at any time. Or they may play in one of two play areas.

Staffing

Center director **Stephanie Wolf** has an early childhood degree, and **staff members include nurses, certified nursing assistants and early childhood aides,** according to Diane Parker. Some staff members, she adds, have training in both the early childhood and nursing fields.

The center maintains basic ratios of 1:3 for infants, 1:6 for ages 2 1/2 to 6 and 1:8 for older children.

Activities

When the children arrive, they have circle time, during which a staff member goes over emergency procedures and talks with them about why they're there, why they don't share toys in the center, and other matters regarding their stay.

"We've never had a problem with children picking up other illnesses."

Diane P. Parker

A **free-play period** follows, during which the children have access to "lots of games and toys, video games and art supplies. They play individually or with caregivers."

During their stay, they're served **two snacks and lunch.** After lunch, all the children rest, and during that time, the center is cleaned and disinfected. While this is a formally scheduled time for cleaning and disinfecting, says Diane Parker, those jobs are done throughout the day as needed.

Sanitary Procedures

As in all sick-care centers, a major concern is that children don't contract illnesses from each other. "The center is kept very clean," says Diane Parker. "No toys are lying about. Every toy is disinfected before going back into circulation.

"We teach the children to wash their hands frequently. Caregivers wear smocks that can be changed if they get soiled.

"We've never had a problem with children picking up other illnesses."

Keeping Records

The staff records information about each child during the day, including periodic temperature, pulse and respiration readings; notations about how the child seems to be feeling; what medicine was given; and when and what the child ate and drank. **At the end of the day, the sheet is given to the parent.**

The center maintains other basic records, including registration, medical release and admission forms, health records and physicians' reports.

In Conclusion

Diane Parker's advice for those who want to start for-profit sick-care centers: **"It's expensive to provide the care, and you need to be able to count on enough money each month to cover costs.**

"To do it the way we do, you have to be in an area where there are enough companies — companies that want to help their employees. Another big plus for us is that we're located close to the companies we serve, so parents can visit at lunchtime.

"It's providing an incredibly great service. Many people today don't have backup care, because their families don't live nearby."

For more information, contact:

Tamie L. Schrimshaw
Bearly Sick, Inc.
10005 East 52nd Street
Tulsa, OK 74146
(918) 832-0368

Barbara Smith
Sniffles
155 Washington Avenue
Albany, NY 12210
(518) 436-3447

Diane P. Parker
Feeling Better
335 Moffett Park Drive
Sunnyvale, CA 94089
(408) 745-1400

NOTICE TO OUR READERS

Please write to me if:

- *You have something to share with other owners and directors.*
- *You have additional insight or information relating to an article.*
- *A JCCA article has been particularly helpful.*

Thank you.

Christine Kalbaugh, Publisher

Guidelines For Programs Serving Mildly Ill Children

"Get Well Care: Guidelines for Programs Serving Mildly Ill Children" was prepared by the Arizona Sick Child Care Guidelines Committee, a team of early childhood and medical professionals assembled for the project.

Chaired by **Ellen Orton Montanari**, the committee developed detailed guidelines covering all aspects of caring for mildly ill children while meeting their **medical and developmental needs**.

The various settings in which such care takes place — **regular child-care centers, specialized sick-care centers, family day care homes, hospital-based programs and a child's own home** — are addressed. Individuals involved with each type of program were represented on the committee.

The set of guidelines is intended to be used in two ways:

- ❑ As a resource for organizations, agencies and individuals interested in creating programs for mildly ill children
- ❑ As a recommended model for state regulations covering such programs

Rather than set a base below which no program would be permitted to go, in the manner of most regulations, the guidelines are intended to suggest **high yet achievable standards.**

The thirty-page, 8 1/2 -inch by 11-inch booklet had its second printing in 1995. It was first published in 1988.

"Something very interesting happened with the team," says Ellen Orton Montanari. **"The medical people learned about child development and the early childhood people learned medical material.**

"There are stages that people go through while writing guidelines. They at first tend to concentrate only on their own specialties. For instance, some of the medical people were very focused on the idea that you never know where an illness will lead — fever could be a sign of meningitis.

"As chair, I realized that with all the exclusions being recommended, only well children could attend. Gradually, the guidelines were revised so that a reasonable balance was reached."

This excerpt from **"Get Well Care"** is in the major category HUMAN RESOURCES:

C. Number of staff

Rationale: Number of staff should be commensurate with the demands of the number of children being cared for and the severity of their illnesses. Group size should be such that adequate care is provided and cross contamination is minimized.

1. Programs providing care for ill children should ensure at least the following staff/child ratios for children in attendance. These ratios should be met at all times, including during naps.

Age	Staff/Child Ratio	Maximum Group Size
3 to 36 months	1:3	6
Preschoolers	1:4	8
School age (over 5 years)	1:5	10

2. The program director, if involved only in direct caregiving, may be included in the staff/child ratio. Any staff included in the staff/child ratio should not be assigned other duties, such as housekeeping, cooking, etc.
3. Mixed age groups should adhere to the staff/child ratios and group size required for the youngest child in the group.
4. The director should continually monitor the program to determine if staff/child ratios should be adjusted to increase the number of staff due to activity level or medical needs of children.

Among the areas addressed by the guidelines:

- ✓ Qualifications for directors and caregivers
- ✓ Staff/child ratios
- ✓ Staff orientation and training
- ✓ Consultation with medical and child development professionals
- ✓ Admission procedures
- ✓ Inclusion and exclusion policies
- ✓ Separation of ill and well children
- ✓ Parent/program relations
- ✓ Medication procedures
- ✓ Illness assessment

Continued on page 10

- Interactions among staff and children
- Activities
- Equipment and fixtures
- Hygiene
- Physical environment
- Drinking water and fluids
- Infant care

Ordering Information:

"Get Well Care" may be purchased for $10.95 plus shipping and handling from:
CPG Publishing Company
PO Box 50062
Phoenix, AZ 85076
(800) 578-5549

I Am Your Child

Basis Of The Campaign

The first three years of life are the focus of the *I Am Your Child* campaign, launched in April 1997.

Chair Rob Reiner and the coalition of individuals and organizations participating in the campaign want to direct the nation's attention to the vital importance of those years. Armed with that awareness, it is hoped that Americans will intensify and coordinate their efforts on behalf of all young children.

A major underpinning of the campaign is recent breakthrough research that has tremendously enhanced our understanding of how the brain develops.

Because of advanced technology, including the electroencephalogram (EEG), the Magnetic Resonance Imaging (MRI) scan and the Positron Emission Tomography (PET) scan, scientists can now obtain detailed images of the brain and gain crucial information about how it works.

Some of their findings have contradicted long-held suppositions.

In The World; Not In The Womb

One such finding is central to an understanding of how this research can benefit young children. It is this: **Most of a child's brain development takes place *after* birth.**

As campaign literature puts it, the brain matures in the *world* rather than in the *womb*.

We have long known that a child's earliest experiences and interactions have great impact on his or her emotional and cognitive development and ability to function in later life.

What we didn't know until very recently is that those experiences and interactions **actually change the structure of the brain.**

In so doing, says campaign literature, they are **"shaping the way people learn, think, and behave for the rest of their lives."**

How Does The Brain Develop?

The brain, like all of the body, is made of cells. Its cells multiply at a tremendous rate before birth, so that by the time he or she is born, a baby has approximately **100 billion brain cells**, or *neurons*.

At birth, most of these neurons are not yet connected in networks. Neuron networks must be formed in order for thinking and learning to take place.

As the child experiences the world and forms attachments to parents and others, the neurons connect with one another. These connections are called *synapses*.

By the time the child is ten years old, trillions of synapses have been formed. Each neuron may be connected to as many as 15,000 other neurons, forming a complex network which is often referred to as the brain's "wiring" or "circuitry."

In the book, **"Rethinking the Brain,"** author Rima Shore illlustrates that process by describing this interaction between a mother and her baby:

> "Beeboo," she says.
>
> "Peekaboo," her mother answers, spreading one hand in front of her face and trying to change her diaper with the other.
>
> "Beebeebeebeebee," she sings, waving her arms excitedly.
>
> "Peekaboo, I see you. There's my baby!"
>
> And in a matter of seconds, thousands of cells in this child's growing brain respond. Some brain cells are "turned on," triggered by this particular experience. Many existing connections among brain cells are strengthened. At the same time, new connections are formed, adding a bit more definition and complexity to the intricate circuitry that will remain largely in place for the rest of her life.

How Can We Help?

"In the early years, children's brains form twice as many synapses as they will eventually need," writes Rima Shore.

"If these synapses are used repeatedly in a child's day-to-day life, they are reinforced and become part of the brain's permanent circuitry. If they are not used repeatedly, or often enough, they are eliminated. In this way, experience plays a crucial role in 'wiring' a young child's brain."

When, for instance, an infant hears words over and over, the parts of the brain that handle speech and language are developed. Even though the infant can't speak or understand words, the more "conversations" he or she has with parents or others, the more those parts of the brain develop.

On the other hand, a young child who is rarely spoken to or read to may have trouble mastering language skills in the future. Or a child who is rarely played with could later have difficulty with social adjustment.

In the booklet, **"The First Years Last Forever,"** the campaign offers several recommendations that we can share with caregivers and parents for fostering healthy brain development in young children. Among them:

- **Be warm, loving and responsive:** "We have always known that children thrive when they feel secure; now we know that children's early attachments actually affect the way their brains work and grow."
- **Respond to a child's cues and clues:** "The baby expresses his distress by crying. When the caregiver responds and provides food or warmth or comfort, the baby tends to be calmed. The stress-response systems in the brain are turned off and the infant's brain begins to create the networks of brain cells that help the baby learn to soothe himself."
- **Talk, read and sing to children:** "You can read picture books and stories to very young children, even to infants. By about six months, infants show their excitement by widening their eyes and moving their arms and legs when looking at a book with pictures of babies or other familiar objects."
- **Establish routines and rituals:** "Repeated positive experiences, which form strong connections between neurons in the brain, provide children with a sense of security."

This article is based on information from "Rethinking the Brain," "The First Years Last Forever" and "Brain Facts," an article on the campaign's Website.

The JCCA will continue to report on the I Am Your Child campaign. "Rethinking the Brain" will be reviewed in a future issue.

For more information, contact:

"I Am Your Child" Campaign
1010 Wisconsin Avenue NW, Suite 800
Washington, DC 20007
(202) 338-4385
Website: www.iamyourchild.org

Staff Teams in Child Care: Children's World Learning Centers

This is the first in a series of periodic articles describing how different centers interpret and execute the team concept. For this article, we spoke with Karen Maggio.

Introduction

Karen Maggio is vice president of human resources for Children's World Learning Centers. Among her responsibilities are giving training workshops and managing training programs for Children's World directors and other personnel. She also gives presentations elsewhere, including at the University of Wisconsin-Stout and at national and affiliate conferences of the National Association for the Education of Young Children.

Children's World has approximately 13,000 employees, according to Karen Maggio. More than fifty percent of its over 500 centers are accredited, she adds, and almost all of the others are in the self-study phase of the accreditation process.

How Are Your Teams Structured?

The team concept is an important part of Children's World philosophy. The people in each center are

considered a team, and there are district teams made up of approximately ten schools each as well.

However, says Karen Maggio, the concept isn't interpreted to mean that each center is required to embrace a formal team structure. Rather, the aim is to create a cooperative, positive atmosphere based on trust, open communication and sharing. How individual directors interpret and act on that basic foundation is varied and covers a wide range.

What's The Most Important Element Of An Effective Team?

"The foundation of an effective team is trust," she says. "In our training, we use a number of exercises to teach the importance of trust.

"With over five hundred locations, we have an open lab. We can make assumptions.

"Usually, when teams don't work, it's because people don't trust each other."

How Is Trust Developed?

Learning more about each other leads to understanding and trust, she says.

"Part of trust is finding commonalities. But we should also learn what's special about each person — appreciate others for their uniqueness.

"Diversity makes a team a strong unit. One person may be good at reports, another at speaking before groups, and so on." Appreciating and utilizing these abilities "makes a team richer."

Another component of trust and good teams is open communication "to, within and from the team," she adds.

What's A Good Training Exercise To Teach Team Principles?

Karen Maggio often uses this **"Rope Trick"** in her workshops:

She sets two rules — there is to be no talking, and the group cannot choose a leader.

Participants are blindfolded. She tosses a rope into the center of the group and asks each person to grab a section of it. Then she directs them to form a shape — four people might be told to arrange themselves into a square, for example.

When the blindfolds are removed, the group discovers that it hasn't successfully created the shape.

They are again blindfolded and assigned the same task. This time, however, they're allowed to talk. **"Typically," she says, "one person emerges as a leader."** The participants find that when they can communicate, they're able to make a far more successful shape.

She asks participants how they felt when they were in the first situation. "They say they feel insecure and uncertain. Some of them freeze. With no leader, there's no direction."

Among the principles the game and the discussion afterward bring out, says Karen Maggio, are that team members should:

- ❑ Designate a leader.
- ❑ Speak up when they have better ideas.
- ❑ Talk openly among themselves.
- ❑ Recognize the importance of everyone doing his or her part; understand that each person has an obligation to the team.

Sometimes, she adds, there's a third trial. This time, there are no blindfolds, and participants may talk freely. "But it's the second time that makes the real impact."

What, Besides Trust, Does A Team Need To Work Optimally?

It's essential, says Karen Maggio, that there be "clarification of roles, goals and procedures."

Members need clearly defined **roles**. Each member must know the responsibilities and scope of his or her position. Those roles can change, she says, but people need to know where they stand at all times.

The team has to understand its **goals**. "They have to know what they're supposed to do, or they can't do it."

Procedures must be developed. The members have to decide how they will operate as a team. "They have to ask themselves, for example, 'What do we do if we run into problems?' "

How Important Are Procedures For Conflict Resolution?

"They're extremely important. And it's crucial to establish them at the beginning, before there are any problems.

"At first, people can't even imagine that problems may develop in the future. But there will always be disagreements. That's why they need processes for

handling conflict. It becomes so much easier to deal with if you know what to expect. There are far fewer hurt feelings."

Why Do So Many Of Us Have Trouble Dealing With Conflict?

"People in the early childhood field tend to be pleasers. They don't like to say tough things to people.

"Many directors have trouble dealing with teachers on performance issues, and with parents in unpleasant situations — when fees are late, for instance."

How Can We Improve In That Area?

Facilitating — or coaching — is at the heart of the team concept. If the director perceives him- or herself as a member of the team; as a coach rather than simply as "the boss," and if the staff has that perception as well, a positive atmosphere is likely to exist.

Therefore, says Karen Maggio, "Directors should **create a coaching environment** from the beginning.

"Let employees know what you expect right up front. And explain to them that you'll guide them; will tell them, 'Your voice was a little loud during that activity,' for example, and that you'll do it privately.

"They have to understand that you're their coach; that your corrections are for their benefit and will make them better at what they do."

How Should Employee Conflicts Be Handled?

Staff members should also be coached into solving their own conflicts, she says.

"The director **must equally support** all employees. When he or she takes a stand in these conflicts, things get out of balance.

"The director should get them both in the room at the same time and set ground rules. Each person should be able to respond to the other's comments. At the end, they come to their own solution.

"The director's role in this situation is to be a mediator."

How Empowered Are Your Staffs?

"The culture in the educational field is largely a consensus kind of culture. The attitude is that if everyone agrees, the better off we'll be.

"The amount of empowerment given to an individual is relative to a person's experience. New people need more support at first. They want more direction.

"Teams need empowerment. A task team may be responsible, for example, for determining playground time, working on a fundraiser, solving problems or planning a family event. The team has to know what it's responsible for and be able to make decisions.

"It has been my experience that the longer a person has been a director, the more open he or she is to delegating, and to empowering and trusting employees."

Karen Maggio

"Some exceptional directors have taken the team concept to its full advantage and empowered their entire staffs; given them a great deal of responsibility.

"It has been my experience that the longer a person has been a director, the more open he or she is to delegating, and to empowering and trusting employees.

"New directors sometimes want to do it all themselves. That isn't necessarily a negative thing; they may want to learn every aspect of running a center. After two to three years, they hit a realization that delegating is good for employees — that they can be trusted and given opportunities to develop their own skills. They learn that empowerment benefits everyone."

How Long Does It Take A Team To Function Optimally?

There is wide variation, says Karen Maggio.

"Sometimes it comes naturally, and it can happen within the first month. Or it can take much longer."

One factor that affects the process is, "The team is always changing. In six months, you may not have the same members. There is great fluidity.

"Research shows that there are some patterns — stages that teams go through as they work together. I think the stages are very valid, but I don't believe there's a particular time line for when each stage occurs."

Do All Your Directors Support Staff Teams?

"It's rare to find someone who doesn't find in time that teams are more effective. But even without them, you can make it a fun place and reward individuals for good work.

"I think it's better if people are trusted and empowered, but it's not necessarily bad if that's not emphasized. It only happens about five percent of the time, but the director may have some magic that makes it work.

"Directors also have unique talents and backgrounds."

What Are The Major Benefits Of Teams?

"You get a feeling when you walk into a center that's working cooperatively. There's an upbeat atmosphere and more smiles and laughter. You sense the trust."

In workshops, she stresses that children, parents and staff benefit from teamwork.

Children gain from:

- ❑ Being in a calm, friendly environment.
- ❑ Making good transitions when they move on to new rooms.
- ❑ Interaction with their siblings' rooms.
- ❑ Observing good examples of how people work together.

"I remember, when I was a new director, hearing two teachers shouting in front of the children. A center has inherently high energy and high responsibility. You don't want that to translate into high stress."

Parents are served because:

- ❑ There is likely to be less turnover; more stability in the staff. Parents can get to know staff members and become comfortable with them.
- ❑ The director isn't constantly training new staff, and is able to do more qualitative work to improve the center.

Staff members profit because:

- ❑ "It's rewarding to be in a workplace where everyone respects you for what you are — where they're not looking for peccadillos."
- ❑ "Pay is not everything. The work environment is very important."

What Final Advice Do You Have For Building Staff Teams?

"Trust that people want to succeed and will do a good job. Work from that foundation. You're the conduit. Help each person to appreciate what others do. You bring the pieces together.

"You have a singular role."

For more information, contact:

Karen Maggio
Children's World Learning Centers
573 Park Point Drive
Golden, CO 80401

In Issue 216, typical stages of team development will be discussed, and techniques for motivating and facilitating teams will be presented.

If you have developed a staff team and would like to share your experience and observations with your colleagues, please contact Christine Kalbaugh.

Guide For Childhood Emergencies

A flip-chart, "Childhood Emergencies: What to Do," is a quick reference guide for taking the first steps when sudden illnesses or injuries strike children in your center. You might want to place one in each classroom, and it's also suitable to recommend to parents and babysitters.

Prepared by the Marin Child Care Council of San Rafael, California, the chart was first published in 1989 and is reviewed and updated periodically. The latest update was in 1996.

The emergency procedures were written in cooperation with the Marin County Maternal, Child and Adolescent Health Staff of the Department of Health and Human Services and the Marin County Child, Adolescent and Parent Health Advisory Board. They were reviewed by pediatricians, pediatric dentists, a pediatric nurse practitioner and the Marin County Regional Chapter of the American Red Cross.

Spiral-bound at the top and sized 8½ by 11 inches, the chart is produced on sturdy paper and may be

hung on a wall. On the cover page is a section for recording EMS, fire, police, poison control, hospital and physician phone numbers.

The index, also displayed on the front of the chart and protected by a clear plastic sheet, is formed by the actual pages, which are progressively sized so that the bottom of each appears as a strip bearing its category. Categories are displayed in six alternating bright colors, further facilitating instant access.

Emergency Categories Covered

- Introduction • General Information for Emergencies
- Abdominal Pain
- Headaches • Head Injuries
- Convulsions • Seizures
- Broken Bones • Possible Spine Injuries
- Toothaches • Broken Teeth
- Abrasions • Cuts • Splinters • Wounds
- Eyes • Ears
- Frostbite • Freezing
- Burns — Chemical or Heat
- Bleeding — Action and Safety
- Shock • Fainting • Heat Stroke • Electrical Injuries
- Bites — Animal and Insect
- Childhood Immunization Checklist
- First Aid Kit
- Poisons
- Choking
- Communicable Diseases
- Prevention — Diapering Recommendations
- Prevention — Proper Handwashing Techniques
- CPR • Lack of Breathing • Cardiac Arrest • Water Rescue • Rescue Breathing

Ordering Information:

"Childhood Emergencies" may be purchased for $13.95 (quantity discounts are available) plus handling and shipping from:
Bull Publishing Company
PO Box 208
Palo Alto, CA 94302
(800) 676-2855

To Share With Parents

"You and Your Baby: A Special Relationship" and **"You and Your Baby: Playing and Learning Together,"** both by Eleanor Eley, are designed to teach parents about playing with and disciplining their babies.

Written at a third-grade reading level, they were specifically created for low-literacy readers.

The 8½-inch by 5½-inch booklets are produced on high quality, glossy paper and are attractively formatted.

A page is devoted to each major concept. The main idea is clearly stated and briefly explained, and ways to implement it are suggested.

On the facing page, a full-page black-and-white photograph and one-sentence summary — for example, "You are your baby's most important teacher." — illustrate the concept. The multicultural photos of parents and babies feature actual clients of the publisher, The Corner Health Center, which provides medical care and health education for adolescents.

"A Special Relationship" explores fifteen aspects of disciplining babies, beginning with "Discipline Means to Teach and to Set Limits." Examples: "You Can't Spoil Your New Baby," "Your Baby Copies You and Does What You Do," "Saying 'No' to Your Baby," "If Your Baby Bites or Hits." The last page of the booklet is for noting "memorable firsts" and important phone numbers.

"Playing and Learning Together" offers sixteen main ideas related to the importance of play in the parent-baby relationship. Examples: "Feeling, Holding and Touching," "Read to Your Baby," "Play Hide-and-Seek Games," "Your Baby Likes to Do Things by Herself."

This booklet has a removable chart that lists six specific play activities for parents to begin with babies at approximate two-month intervals, "From Birth On..." through "From About 10 Months On..." Because of this, plus the insight and many excellent play suggestions throughout, the JCCA recommends this booklet not only for those with low literacy, but for other parents as well.

Continued on page 16

For further information, contact:

The Corner Health Center
47 North Huron Street
Ypsilanti, MI 48197
(313) 484-3100

Individual booklets cost $2.65 plus tax and 15 percent shipping and handling. Bulk rates are available.

Here is an excerpt from **"You and Your Baby: A Special Relationship":**

Tell Your Baby When He's Good

When your baby does something that you like, give him a big smile and a hug. Clap for him. Praise him. Say "Good for you!" or "Thank you!" Tell your baby when he's good.

Some people think that you need to spank children. Others don't agree. No matter what you think about spanking older children, it is never okay to spank a baby. Spanking and shouting at your baby scares him. It teaches him that hitting others is okay. If you spank and shout at your baby, he won't understand because he is too young. Spanking and yelling will hurt and scare your baby.

Peanut Allergy Alert

Johns Hopkins Children's Center warns that peanuts are believed to be one of the **leading causes** of food-allergic reactions, and one of the major causes of **fatal and near-fatal** food-induced reactions.

And peanut allergy is on the rise in America. It may affect one in every 200 children and thousands of adults.

"Allergists, pediatricians and emergency room physicians are reporting more cases than ever. At the Hopkins Children's Center, for example, the number of patients with peanut allergic reactions doubled from 1981 to 1991," according to a Center fact sheet.

Hugh A. Sampson, M.D., a Hopkins Children's Center professor of pediatrics who has published research on the subject, "surmises that in today's environment, children are exposed to more peanut products (e.g. peanut butter crackers, peanut butter and jelly sandwiches and peanut butter candies) at a younger age when their immune systems are not mature enough to tolerate allergens found in peanut proteins."

He recommends that **peanuts not be given** to children **under three years old** who have **asthma** or a **family history of peanut senstivity,** or whose parents have **hay fever, eczema, asthma or other food allergies.**

Allergic reactions to peanuts can include hives, swelling of the throat, breathing difficulty, vomiting and anaphylactic shock, which can be fatal if not treated.

Unlike allergies to other foods, such as eggs and milk, which are commonly outgrown, peanut allergy is generally a **life-long** condition, according to Dr. Sampson. Along with shellfish, he adds, it is **one of the most violent food allergies.**

People who are allergic to peanuts have to avoid all foods that contain peanut products, as well as those prepared with cooking utensils used to make peanut-containing food, the fact sheet warns.

Finally, it notes that removing peanuts from a food — ice cream, for example — does not remove the contaminating protein that causes the allergy.

For more information, contact:

Johns Hopkins Children's Center
111 Market Place, Suite 901
Baltimore, MD 21202
(410) 223-1730

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JCCA JOURNAL OF CHILD-CARE ADMINISTRATION

Issue 216

A National Publication Addressing The Concerns Of:
Child-care Centers Learning Centers Preschools Nursery Schools Kindergartens Intergenerational Centers

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Including Children With Disabilities
Interview With Susan E. Craig, Part 1

Susan E. Craig, Ph.D., is director, special projects of AGH Associates, a company which since 1983 has helped schools and child-care centers accommodate children with disabilities.

Formerly, Dr. Craig was an early childhood teacher. After becoming certified in special education, she ran a program for emotionally disturbed children for ten years. Her doctorate is in sociology.

In this interview, Dr. Craig talks to administrators about preparing themselves and their staffs for including children with disabilities.

Fear Of The Unknown

Owners and directors know that the Americans with Disabilities Act and other laws require that children with disabilities be included in typical settings, in age-appropriate groups, to the greatest extent possible.

But many who not only know of that directive, but fully approve of and even applaud it in principle, are nonetheless daunted by the prospect of applying it in their centers. They have serious concerns about safety, lack of special training and other issues. So do their staffs.

Administrators' Training Materials

AGH addressed those concerns through a demonstration project coordinated by Susan Craig.

Funded by a U.S. Department of Education grant, its goal was to develop training materials for early childhood administrators to use to prepare their staffs to include children with disabilities.

From 1991 to 1992, training sessions were conducted at two Army and four civilian child-care centers. In 1994, the print version of the sessions was tested at a Tacoma, Washington center. **The materials are now used in all U.S. Army child-care centers worldwide, as well as in civilian centers.**

Through another federal grant, the project is being extended to Texas, West Virginia and the Virgin Islands. A major focus of that outreach effort is fostering the care of children with disabilities in natural settings by creating strong partnerships

between early intervention specialists and child-care directors.

Based On CDA Modules

The AGH **"Including All Children"** training materials are grounded on this major underlying assumption: To care for children with disabilities, administrators and caregivers need to build on **skills they already possess and practices they already follow.**

In line with that premise, the materials are based on the Child Development Associate Credential modules developed by the Council for Early Childhood Professional Recognition.

To initiate the project, Susan Craig says, "We put the CDA modules through a series of reviewers — special education professors and other experts across the United States. We asked them to determine which of the modules needed enhancement for the care of children with disabilities.

"The consensus was that ten of the modules needed to be modified. The others could be used regardless of whether children had disabilities or not.

"The next step was for the reviewers to go line by line into how the ten modules could be enhanced."

The resulting material was published after onsite training to establish its reliability.

Which Stage Are You In?

One goal of the project was to identify elements necessary for the successful inclusion of children with disabilities in child-care programs.

Unsurprisingly, one of the major findings was that **owners and directors are absolutely critical** to that success, from the initial motivation and training of staff through ongoing encouragement and support.

According to Susan Craig, her research has shown that child-care administrators typically go through three stages in their commitment to integrated child care:

1. No Commitment

"At this stage, administrators are anxious to involve caregiver staff in training, but more for the purpose of upgrading provider skills with other children.

"They correctly assume that training on topics related to children with disabilities will do this, but make no commitment to enrolling these children."

2. Commitment to the Concept of Inclusion

"Administrators at this stage are aware of the child-care needs of children with disabilities and recognize the benefits offered by participation in a center-based program.

"*If approached*, they will enroll a child with disabilities."

3. Active Recruitment

"Administrators at this stage understand that the inclusion of children with disabilities can improve program quality for all children enrolled in their program, and actively recruit their participation."

Reaching Stage Three

Before you can convince your staff that actively seeking inclusion is good for all concerned, you have to fully convince yourself.

To do that, you need to know the answers to two questions:

- How are children with disabilities helped by inclusive programs?
- How do inclusive programs benefit typical children?

How Do Centers Help Children With Disabilities?

Many very kind and well-meaning people, including child-care administrators, care very much about children with disabilities but are troubled by a nagging question: **Can't their needs be better addressed in a special setting, with specially trained staff?**

No, say experts.

One reason is the importance of peer modeling. "Including All Children" materials note, "First, research shows that children learn most from other children. Secondly, identifying with children their own age is important. Children learn more about social skills and independence in a peer group than they do one-on-one with an adult."

When children with disabilities are segregated in institutions or in separate rooms — the usual practice until quite recently — they have only each other as peer models. They often develop behavior and mannerisms that further separate them from society.

When they live and learn right along with other children their age, they have an incentive to participate in life to the fullest extent possible. By playing with and watching other children, they develop skills and take part in the interaction and fun that all children are entitled to experience.

Another reason that experts recommend inclusion is that it fits in with what is currently known about child development.

"Including All Children" materials use a ladder and a hopscotch board to demonstrate old and new child development theories.

Traditionally, they point out, **development was thought to be like step-by-step progression up a ladder.** If a child reached a "broken" rung — a developmental skill or set of skills that he or she couldn't fully master — that step was considered the limit of that child's ability. There could be no advancement to a higher rung.

Current theory is more like a hopscotch board, the Administrator's Handbook notes, with a whole range of activities on each square: "You can jump in anywhere. You can do the squares in any order. You can do as many squares as you can.

"Wherever I go, I find that children are much happier in centers. Children are motivated by other children."

"Each square is a set of activities children are doing. Maybe you can join in all the activities, or maybe you can only do a few. Or maybe you just enjoy being there — getting to see what goes on in life with kids your age."

Susan Craig says, "Wherever I go, I find that children are much happier in centers. Children are motivated by other children. Just one example that comes to mind is a child who had mild cerebral palsy. After several months in center-based care, he was pulling himself up on chairs and wanting to practice walking with his mother.

"A strictly therapeutic environment is not motivating, especially to young children.

"Something's always going on in a child-care center that they have to practice. They get to repeat many skills. So much learning occurs by exposure to the routines of other children.

"There are lots of finger plays, songs, rhyming games. These are incredibly beneficial to children who don't understand the purpose of language; those with autism, for example. It helps them to match their environments with words that go with them. They tend to be less frustrated when they learn how to label things; to ask for, 'Juice, please.'

"A major reason that people tend to avoid those with some kinds of disabilities is that physical behavior takes the place of language. When they learn to interact verbally, they increase the desire of others to be with them.

"And a family benefits from having the child in a natural environment like a child-care center. For example, children with high startle reflex may scream when they go to the mall. But you don't see that as much in junior high kids who have had child care with typical children. They have become accustomed to noise over time. That makes it less stressful for them and their families. They can go to McDonald's.

"In my position, I see people in natural and segregated settings, and the difference is shocking. Purposeless behaviors perpetuate themselves when children have no other model."

How Does The Center Benefit?

Inclusion is good for your center because it's the right thing to do.

You and the center you head are forces for enlightenment and education, so it is extremely satisfying to know that by including children with disabilities you're not only benefiting them, but the society at large.

You're helping to change and shape attitudes — those of your staff, parents of other children in the center, residents of the community, and most important of all because they are the future — of children.

But, says Susan Craig, there is a very important "selfish" reason as well: Caring for children with disabilities requires that you're always at your best; that you use best practices.

Here are examples she gives:

"A provider may habitually talk to another adult while diapering or feeding a child. It's not a good practice, but a typical child can deal with it. Many children with disabilities can't. They'll become more languid and inattentive.

"Consistent routines are good for all young children. But typical kids can stand variations. Children with disabilities often can't. An at-risk child can fall apart when you take the routine away.

"Having children with disabilities encourages providers to be at their best. It will probably increase the number of their 'best days.'

"I try hard, when I'm training providers, to emphasize their existing skills, rather than have a special-education emphasis. For example, they need to provide access to materials, eliminate lag time and make transitions clear and dramatic.

"These practices are good for all children, but children with disabilities are more reliant on the routines."

How Can You Succeed?

Once you and your staff understand that everyone benefits from inclusion, there is one more, tremendously important question left: **Are we capable of doing this?**

To that, experts emphatically answer, "Yes."

Success, they say, depends on four basic elements, all of which are attainable:

- ❑ Awareness and Sensitivity Regarding Disabilities
- ❑ Positive Attitudes
- ❑ Effective Training
- ❑ Access to Community and Other Outside Resources

In Part 2 of this article, Susan Craig will suggest steps that directors may take to prepare staff for inclusion. She will also discuss working with an Early Intervention team and share specific techniques for caring for children with disabilities. Excerpts from "Including All Children" training materials will be presented.

For more information, contact:

Dr. Susan Craig
AGH Associates, Inc.
PO Box 130
Hampton, NH 03843
(603) 926-1316

"Including All Children" training materials may be ordered from the same address.

AGH publishes a newsletter, "Early Childhood Links," twice a year. Its purpose is to share information about caring for children in inclusive environments. Subscriptions are free, although a yearly donation of $5 for an individual and $10 for a center or institution is suggested.

Reprints of the three-part JCCA Special Feature, **"Americans With Disabilities Act: How Does Title III Really Affect You?"** are available. To order, please send a check with your request.

- ❑ Part 1: **Basic Title III Requirements for Child-Care Facilities**
- ❑ Part 2: **Colleagues Offer Practical Guidance**
- ❑ Part 3: **Experts Share Information and Suggestions**
- ❑ **Parts 1, 2 and 3**: Subscribers $15; Non-subscribers $18
- ❑ **Each part if purchased separately**: Subscribers $6; Non-subscribers $7

AGH TRAINING MATERIALS

Although the grant that produced the **"Including All Children"** training materials was for a demonstration project in infant and toddler programs, project coordinator Susan Craig notes that the materials are suitable for the care of preschool-age children as well.

"The grant was for up to age three," she says, "but we were conscious of the older ones while we were doing the research and preparing the materials."

Here is a brief description of the basic AGH materials for training child-care staff to include children with disabilities:

Administrator's Handbook

This is an 8 1/2-inch by 11-inch, 3-ring notebook with just under 100 pages.

It provides administrators with the background information they need in order to prepare their centers and train their staffs for caring for children with disabilities. It has four units.

"Thinking About Inclusion" discusses:

- The philosophy and benefits of inclusion
- How caring for children with disabilities draws on the same skills and practices that benefit typical children
- Current child development theory that supports total inclusion
- Different categories of disabilities
- Several specific syndromes
- Causes of different kinds of disabilities
- Recommendations for teaching caregivers how to view and work with children with disabilities
- Ways to help and support caregivers

"Getting Started" provides:

- An overview of laws regarding inclusion
- A description of how Early Intervention works
- Explanation of how Individualized Family Service Plans are created and implemented
- Sample IFSPs

"Supporting Inclusion" covers:

- Specific policies and procedures that comply with the Americans with Disabilities Act
- Hiring staff suitable for inclusive programs
- Obtaining and organizing resource materials
- Marketing your inclusive program
- Forming and working with an advisory committee

"Financing Inclusion":

- Discusses budgetary concerns about inclusion
- Notes sources of financial help for families of children with disabilities
- Lists addresses and phone numbers of organizations offering assistance and information regarding disabilities
- Details specific requirements of the ADA

Self-Paced Modules

The ten modules into which the course is divided are: **Safety, Health, Environments, Physical, Cognition, Communication, Social, Guidance, Families and Preventing Child Abuse.**

A caregiver booklet is based on each module. Each booklet, introduced by a brief overview, gives detailed information on its topic as it relates to caring for children with disabilities.

The reusable booklets are the core around which staff workshops are organized, and may also be used as a self-paced course.

Emphasis is on using and adapting caregiver skills that benefit all children. At the beginning of each chapter is a feature comparing "What every caregiver knows" about facets of the topic with "What's new" — adaptations that need to be made for children with disabilities.

The booklets, written at fifth grade level, present information in a natural, conversational style.

Basic text is supplemented by the recurring feature, "What Do You Think?" which sets up a realistic situation involving a child with a disability, describes three possible ways for a caregiver to respond, then explains why one of the approaches is more likely to benefit the child.

Although specific disabilities are mentioned, the emphasis is on their effects rather than their causes. It is pointed out, for example, that a child may have low muscle tone for various reasons. What is important is to determine how to adapt the environment so that the low tone doesn't prevent the child from participating in activities.

Interspersed throughout the booklets are the remarks of five caregivers who have worked in inclusive programs. They talk about how their feelings and attitudes have evolved over time, and explain how they worked out adaptations for specific children.

By artfully weaving straight information, instructive vignettes and candid conversations, the booklets convey a great deal of vital information in an interesting, non-technical way that invites the caregiver to gradually become comfortable with the idea of inclusion.

Each booklet ends with a bibliography.

Continued on page 6

Trainer's Guide

This 85-page book has an introductory chapter that explains how the materials are organized and offers overall suggestions for conducting training sessions and building staff attitudes and knowledge.

The remaining chapters provide lesson plans for ten ninety-minute workshops. Each workshop is based on one of the modules into which the course is divided and follows the format of the caregiver booklet for that module.

Each chapter sets out the purpose of the session, the themes to be developed and the materials that are needed. The trainer may read the text aloud or use it as a guide. A recommended time span is given for each segment of the session. At the end of the chapter are master copies of handouts.

Two Videos

"Disability Awareness" is a 7-minute video that can serve as an introduction to the idea of including children with disabilities. With a backdrop of colorful photos of caregivers interacting with children at child-care centers, it explains the overall philosophy of inclusion.

An accompanying "Trainer's Guide" booklet provides discussion and activity material intended to be used with the video to create a one-hour workshop.

In addition to those who work directly with children, AGH recommends that the video workshop be held for all staff, and for parents of children enrolled in the program.

"It's Really No Different" is a 17-minute video in which caregivers who have worked in inclusive programs discuss their experiences and feelings.

It comes with a "Discussion Guide" booklet that provides discussion and activity material for a ninety-minute training session.

NOTICE TO OUR READERS

Please write to me if:

- ✓ ***You have something to share with other owners and directors.***
- ✓ ***You have additional insight or information relating to an article.***
- ✓ ***A JCCA article has been particularly helpful.***

Thank you.

Christine Kalbaugh, Publisher

Update: SIDS and Sleep Position

Through periodic reports, **JCCA** keeps its readers aware of new and important developments regarding the prevention of SIDS — sudden infant death syndrome. This article is part of that ongoing effort.

"Back to Sleep" Campaign

"Back to Sleep" is a national information campaign. It is a joint enterprise of private and government organizations.

Its main recommendation is to place healthy infants on their backs for sleep.

Among the federal agencies with leading roles in the campaign are **National Institute of Child Health and Human Development** (NICHD), **Maternal and Child Health Bureau, Centers for Disease Control and Prevention** and the **Census Bureau.**

Private partners include **American Academy of Pediatrics, SIDS Alliance** and **Association of SIDS and Infant Mortality Programs.**

Winning the Fight Against SIDS

SIDS is the sudden death of an infant under one year of age that remains unexplained after a thorough investigation. Research to determine its exact cause or causes is continuing.

One relationship that *has* been established is that between SIDS and sleep positioning.

Over time, research from several countries has demonstrated that babies who sleep on their stomachs are more likely to die of SIDS than those who sleep on their backs.

According to a pamphlet, "Sudden Infant Death Syndrome," published by NICHD in April 1997, **"Studies have shown that placing babies on their backs to sleep has reduced the number of SIDS cases by as much as a half in countries where infants had traditionally slept on their stomachs.**

"Although babies placed on their sides to sleep have a lower risk of SIDS than those placed on their stomachs, the back sleep position is the best position for infants from one month to one year."

If a baby is placed on the side, the lower arm should

be brought forward, to lessen the likelihood of the baby rolling onto the stomach, the campaign states.

Saving America's Infants

Since 1992, Americans have been advised to stop putting their babies down prone — on their stomachs — to sleep, as they traditionally have done.

And, said the NICHD in a November 1997 statement, **"The success of this recommendation is borne out in the recent reduction in infant mortality rates.** This trend has continued with a 7.2 percent drop in infant mortality this year.

"This reduction is largely due to the 38 percent reduction in SIDS deaths rate between 1992 and 1996 (U.S. Vital Statistics)."

The statement further notes: **"Prior to the campaign there were nearly 5,000 unexplained SIDS deaths a year in the United States. That number has now dropped to fewer than 3,000."**

Some Centers Don't Follow SIDS Guidelines

A study published in "Pediatrics," the journal of the American Academy of Pediatrics, suggests that staff at many child-care centers may be unaware of the association between infant sleep position and SIDS. There were other revealing findings as well.

Of 131 licensed child-care centers that care for infants under six months old:

- Forty-three percent were unaware of the association between SIDS and infant sleep position.
- Forty-nine percent placed infants to sleep on their stomachs at least some of the time.
- Twenty percent positioned infants exclusively on their stomachs for sleep.
- Seventy-five percent did not have written policies regarding sleep position.
- Twenty-six centers that were aware of the "Back to Sleep" recommendations nonetheless placed infants on their stomachs for sleep.

Why Were Infants Placed Prone?

The most common reasons for placing infants on their stomachs to sleep included:

- Comfort
- Fear of choking
- Guidance by the parents

Are the Reasons Valid?

• **Comfort:** The study notes: "Indeed, studies of sleep position have identified longer, quieter sleep for infants sleeping prone, and prone sleeping has been associated with higher arousal thresholds to environmental noises.

"However, it is also acknowledged that the deeper sleep experienced by prone infants may itself be a factor in SIDS."

Waking when the brain senses a threat, such as inadequate intake of air, is a lifesaving mechanism.

• **Fear of choking:** Campaign literature notes that **there is no evidence that healthy babies are more likely to experience serious or fatal choking episodes when they sleep on their backs.**

"In fact," states a "Back to Sleep" booklet, "Questions and Answers for Professionals on Infant Sleeping Position and SIDS," **in the majority of the very small number of reported cases of death due to aspiration, the infant's position at death, when known, was prone."**

• **Guidance by the parents:** The study found: **"Many child care centers aware of the SIDS risk succumbed to parental insistence that infants be placed in the manner they are accustomed to."**

The center is a prime setting for parents to learn about proper sleep positioning. And a written policy eliminates the need for debating the matter with each new parent.

What Did the Study Recommend?

The study determined that more efforts are needed to educate parents and providers on the importance of proper infant sleep positioning.

Guidelines Are For Healthy Babies

Campaign recommendations regarding back placement are for healthy babies.

Some infants have specific medical disorders that cause fewer problems when they are lying prone. The advice of the child's pediatrician or other health care provider should be sought whenever there is doubt regarding the child's health, the campaign advises.

Other Sleep Recommendations

To reduce the risk of SIDS, the "Back to Sleep" campaign makes these additional recommendations for putting an infant down for sleep:

- ❑ Make sure the baby sleeps on a firm mattress or other firm surface.
- ❑ Avoid fluffy blankets or coverings.
- ❑ Don't put pillows, sheepskins, blankets, comforters or other soft materials under the baby.
- ❑ Don't place an infant on a waterbed to sleep.
- ❑ Don't let an infant sleep with soft stuffed toys.
- ❑ Keep the baby warm, but not overheated. The temperature in the baby's room should feel comfortable to an adult, and overdressing should be avoided.

Spreading the Message

You can order these "Back to Sleep" materials free of charge:

- ✓ **Parent Brochures**: English and Spanish
- ✓ **Professional Brochures**
- ✓ **Logo Stickers**
- ✓ **Door-Knob Signs**
- ✓ **Take-Home Cards**: English, Spanish, Bilingual
- ✓ **Posters**: White Babies and African-American Babies
- ✓ **Videos**: 3-minute English and 4-minute Spanish
- ✓ **Videos**: 60-minute continuous plays of English and Spanish videos

From the November 1997 NICHD statement:

"The goal is to have all healthy babies sleeping on their backs.

"All caretakers need to be reached, including fathers, grandparents and babysitters. Minority groups need to hear the message in culturally sensitive ways. The message needs to be repeated and reinforced in newborn nurseries.

"This effective message is a low-tech, low-cost way to save lives and prevent tragedies."

Statistics in this article were from "Infant Sleep Position in Licensed Child Care Centers," by Naomi B. Gershon and Rachel Y. Moon, M.D., Pediatrics, Vol. 100 No. 1, July 1997.

To order "Back to Sleep" materials by mail, fax or phone, contact:

NICHD/Back to Sleep
31 Center Drive, Room 2A32
Bethesda, MD 20892-2425
(800) 505-CRIB
Fax: (301) 496-7101

I Am Your Child

The Campaign Continues

JCCA is proud to be taking an active role in the national *I Am Your Child* campaign.

Begun in April 1997, the campaign is dedicated to directing America's attention to the crucial importance of the first three years of life.

Free Video

An *I Am Your Child* video, **"The First Years Last Forever," is available free to child-care centers.**

Introduced by **Rob Reiner**, the campaign chair, it informs parents of how they can **apply recent breakthrough findings in brain research** to caring for their children from birth to the age of three.

Prominent experts **Bruce Perry, T. Berry Brazelton, Barbara Bowman, Daniel Siegel and C. Everett Koop** talk about the components of good parenting behavior. Their recommendations are demonstrated in scenes of parents interacting with their babies.

Seven Segments

The video is divided into seven parts. Below are the segments and some of the concepts explored in each:

Bonding and Attachment

- Babies are ready for human interaction from the moment of birth.
- A newborn's secure attachment to at least one caregiver begins "the bonding that science now knows is the most critical factor in a baby's development."
- In the first few months, a major way for parents to bond with their infants is through touch.

Communication

- Infants communicate from the moment they're born. It's important to learn to read their cues and respond appropriately to that communication.
- Language is more than just words. "It's a far more complex mix of inflections, tones and rhythms as well." Therefore, you should sing, talk and read to babies as much as possible.

Health and Nutrition

- A mother's diet, physical condition and stress levels affect the health of the developing fetus.

BEST COPY AVAILABLE

- Parents should know certain basics about feeding infants and toddlers.
- Using car seats and childproofing the home are among the ways to keep small children safe.
- Regular visits with the child's health care provider are essential.

Discipline

- It's impossible to spoil a newborn.
- Discipline is teaching. It involves setting predictable boundaries for children, and being firm but gentle when you do have to correct them.
- Children should never be spanked, hit or shaken.
- Recommended discipline techniques include redirecting attention, limiting choices and time-outs.
- "Discipline should really be all about helping your child learn to regulate himself. And about love — making your child feel good about you, and herself."

Self-Esteem

- Every child is unique from the beginning. Parents should value each child, no matter how different he or she is from their expectations.
- All children need encouragement, honest praise and respect.

Child Care

Regardless of the setting in which a child is being cared for by someone other than the parents, there are "certain universals that signal quality." They include:

- Well-trained, concerned people who understand what children need
- A clean and safe environment
- Healthy and nutritious food
- Low adult/child ratio
- Unrestricted drop-in policy for parents

Self-Awareness

- Parents have to take care of themselves as well as their children.
- Parenting classes can be very helpful.
- Parents should recognize that everyone makes mistakes.

Good Basis for Parent Meetings

JCCA suggestion:

An excellent way to use the video is to schedule a series of parent meetings around the topics it covers.

Show one segment for each of seven meetings. Use it as a starting point for a discussion in which parents, caregivers and administrators share their thoughts, feelings, experiences and expertise on that aspect of caring for young children.

At the end of the seventh meeting, present each participant with a copy of the **companion booklet**, also titled "The First Years Last Forever," which discusses many of the video's topics in detail and can serve as a **summary** of what was covered in the sessions. Ask everyone to read it before the group is scheduled to get together again.

At the final meeting, invite participants to talk about how their **ideas and parenting behavior** have been affected by what they've learned.

If eight meetings are too many for your schedule, **topics can be combined.** Or you may show the entire video at one meeting and hand out the booklets, omitting discussion or discussing only the topics that you think are **most needed** by parents in your program.

CD-ROM Available, Too

A CD-ROM, also titled "The First Years Last Forever," is offered by the campaign as well. It answers a wide variety of questions for parents about the first three years of life.

For each of the four sections — **Ages and Stages, Parent Questions, Brain Facts** and **Key Guidelines** — expert opinion and resources and references accompany the factual material.

To order "The First Years Last Forever" materials, contact:

I Am Your Child
335 North Maple Drive, Suite 135
Beverly Hills, CA 90210

All listed materials are available free to child-care centers and other organizations and professionals serving parents and caregivers. The only charge they are required to pay is shipping and handling for booklets.

- ✓ Include your name, organization name, address and phone number.
- ✓ Request:

  Video: English or Spanish version

Continued on page 10

Booklets: English or Spanish version
(Booklets must be ordered in increments of 100. Include $5 check or money order for every 100 booklets to cover shipping and handling.)

Bounce-Back Cards: If you'd like to make the video or CD-ROM available for parents in your program to keep, you may order these cards in increments of 100. They instruct the holder to send $5 to cover shipping and handling. The video cards are available in English and Spanish.

CD-ROM

Staff Teams: Stages of Development

Staff teams are the focus of an ongoing series of JCCA articles. Here, basic team concepts are noted and typical stages of development are outlined and discussed.

Self-Directed Teams In Child Care

In Issue 214, the origins and evolution of business teams were discussed.

It was noted that the concept of the self-directed team is **not** a trend that was hastily put together and is expected to just as quickly disappear from the business scene.

Rather, it is the product of **serious research and study over time**, and is routinely taught in MBA programs and other university courses.

Self-directed teams are highly suitable to the early childhood field, with its emphasis on cooperation and sharing. Future **JCCA** articles will explore different facets of team implementation in the child-care setting.

Brief Review of Team Concepts

Definition: A self-directed team is a group of two or more people who share **decision-making powers and responsibility** for significant aspects of their **individual jobs**, for how their jobs **interact** with those of other team members and for how their team's contributions affect the overall **organization.**

Other names for self-directed teams are *empowered teams, autonomous work teams* and *self-managed teams.*

Self-directed teams have these characteristics:

- They are considered permanent.
- They set many of their own goals and determine the methods they will use to attain them.
- Members meet regularly to plan, report activities, discuss problems and strengthen group cohesiveness.
- They establish rules, roles and procedures.
- Members are interdependent.
- The leader is an equal member of the team.

These characteristics are more fully discussed in Issue 214.

Who Should Be On A Team?

One basic decision that must be considered is the makeup of a team.

Will there be one team composed of everyone in the center, or is each classroom or other unit a team?

Should aides and non-teaching personnel be on teams?

Such questions need to be answered after considering the individual center's philosophy, methods of operation, and a factor that is likely to play an important role in the decision — size.

Typical Team Stages

While teams may differ in many respects, research has shown that they all tend to pass through distinct stages. Commonly, they are called the **Forming, Storming, Norming** and **Performing** stages, based on a model by Bruce W. Tuckman.

Stage One (Forming)

There is no real "team" at this point; just a group of individuals. The main task of Stage One is for these people to begin to see themselves as a team.

This is the time for **orientation** and basic **planning**. The whole idea of teams is being explored, and a formal team structure starts to be developed. Roles, goals and methods are *beginning* to be addressed.

It is usually a very **positive** stage in some ways. Members tend to be very accommodating toward each other. They seem to like the idea of being on a

team, and to be curious and excited about the uncharted journey before them.

However, beneath the polite, positive exterior lies a certain amount of **uneasiness**. No one is quite sure what to expect, so full commitment tends to be withheld. Communication is somewhat guarded, as members aren't sure that they can fully trust each other.

Stage Two (Storming)

It's now time for the team to really work together; to put its plans into action.

This is when the **reality** of teamwork sets in. Generally conceived ideas need to be fine-tuned to fit actual conditions. Matters that seemed settled show themselves to be much more complex, with many **details** to be ironed out.

Members are communicating more, but they often reach out to individuals to whom they've developed special ties, rather than to the whole team.

Because many issues, like how various tasks will be handled and what each member is expected to do, haven't been completely resolved, there is often **confusion** during this stage, and even **conflict**. Different approaches and personalities may lead to clashes.

Members, who are dealing with these new responsibilities and problems while still working at their individual jobs, may feel **stressed** and overloaded.

At this point, it may seem that the group is going in circles and accomplishing little. Individuals commonly are tempted to save time and effort by doing tasks on their own rather than wrestle with team procedures.

However, it is by diligently working through these very difficult issues that the team matures and develops into a cohesive unit. For that reason, this stage has been likened to **adolescence**, which often tends to be stormy, but serves as preparation for adulthood.

Stage Three (Norming)

This is when the group begins to really become a **working team**.

Members have learned to be comfortable with and **trust** each other. They **communicate** far more freely. They have begun to have true **team spirit**; to think and act like a team.

Ways of working out disagreements have been developed. Members have reached the point where they **accept and accommodate** the differing temperaments and approaches of their colleagues.

Many procedural matters have been resolved, so that work flows much more smoothly. The team can now **focus** on achieving its larger goals.

Stage Four (Performing)

This is the **optimal** stage. It's what all the hard work has been about.

The team is **functioning smoothly** and **accomplishing** its goals. It is making a **significant contribution** to the center.

Diversity is not only tolerated, but **celebrated**, with each person's unique talents being valued and used effectively.

At Stage Four, a team is **highly committed** not only to itself, but to the larger organization as well. It is continually seeking new responsibilities and new ways to improve the center.

How Long Does Each Stage Last?

The duration of each stage can't be predicted.

It depends on many factors, including leadership and the size and makeup of the team.

Stages, in fact, are likely to overlap, rather than begin and end at completely clear-cut intervals. And some experts organize the same progression into only three stages.

There is, however, general agreement that virtually all true self-directed teams go through some version of the sequence.

Can't Stages Be Skipped?

The progression of stages is considered **natural and desirable**.

Each stage has its own challenges to meet and serves as a steppingstone to the next level. If a stage is skimmed over or ignored, its issues are not resolved, and team development suffers.

A group may, for instance, decide that it's going to completely avoid the disputes and discomfort common to Stage Two. And it may be successful in doing so.

In time, however, it will almost certainly find that it has not really developed the tools for becoming an effective team.

Everyone's View Is Crucial

Members who merely "go along" to be agreeable and avoid conflict in the planning stages are likely to be very unhappy when the team begins to function fully.

They will be participating in an environment that they *ostensibly* took part in creating but really did not, and may find it very difficult to work under the new conditions.

For the team concept to succeed, every member must be comfortable with the changes it entails.

Asking people with diverse backgrounds, working styles, talents, attitudes and values to work meaningfully together and share real responsibility is asking a great deal. But it has been widely found to be very worth the effort.

In future issues, ways to guide your staff through the stages of development will be discussed, and other techniques for motivating and facilitating teams will be presented.

If you have developed a staff team and would like to share your experience and observations with your colleagues, please contact Christine Kalbaugh.

Hiring And Training Staff Using Case Studies
Part 1: Using Case Studies For Hiring

Judy A. Bordin, Ph.D., is an associate professor in the child development program at California State University, Chico. In that capacity, she has taught various courses, including "Staff, Parent and Child Relations" and "Administration and Supervision of Child Development Programs." Her doctorate is in human development.

Prior positions included nine years as head teacher of the Child Development Laboratory, a preschool program serving as a training facility at Chico State University.

Through her consulting firm, Dr. Bordin provides in-service training and guidance to human service agencies and schools. Her clients have included Head Start and other child-care programs.

She *participates in many conferences as a presenter and coordinator and has public speaking engagements on various issues relating to discipline, guidance and communication skills.*

The Challenge Of Hiring

It is arguable that hiring is the most important challenge facing administrators.

An enlightened philosophy and creative, developmentally appropriate curriculum are just good ideas until a capable, committed, inspired staff brings them to life.

But assembling that staff is not an easy task, Judy Bordin notes. All too often, an applicant "looks appropriate on paper," is impressive during the interview, and appears to be a "good match" in other ways, but still disappoints on the job.

In such situations, **"Administrators often feel remorse and wonder how they could have screened more carefully."**

One way to avoid that plight, she suggests, may be to devote part of the hiring interview to having the applicant consider and discuss a case study. Her definition: **"A case study is an anecdote or narrative of a real life situation that sets up a problem or unresolved tension that must be analyzed and resolved."**

Giving potential employees possible situations and asking how they might be handled is already an accepted interview technique, she adds. **"What I am proposing is to formalize the process."**

Case Studies Can Help Applicants

When a candidate is given a case study to deliberate, important information is divulged about his or her knowledge, skills and attitudes, says Judy Bordin. **"A potential employee's response to the particulars of a situation can help decide if this person will fit into the available position."**

The approach can benefit the person being interviewed as well as the employer, she adds.

"Most practitioners know more than they can talk about in a short period of time. Responding to the specifics of a case allows them to exhibit their abilities in the context of a real situation.

"Another advantage is that this is a non-threatening technique.

"Sometimes in interviews, applicants are asked

things like, 'Tell me an anecdote of something you did that worked well. Then tell me one you believe could have worked out better.' I think that can make people uncomfortable.

"A case study, because it's in the third person, can seem less threatening."

How Do You Write A Case Study?

Judy Bordin advises:

- Use your own experiences with children, parents and staff or, with permission, the experiences of other people. You can describe an actual event or a composite of several events.
- Be clear about your purpose.

What topic are you trying to address? Does it involve relationships with children? With parents? With administrators? With other staff? With school policies?

It's best to emphasize one of those categories, "reducing the number of tangents and what-ifs."

A Sample Case Study

Judy Bordin offers this example of a case study that might be presented to candidates for teacher or aide positions:

Tim, a four-year-old boy, has been riding his tricycle into the backs of other children's tricycles.

It has been pointed out to him that this is unsafe.

As he rounds the corner near a teacher, Ginger, he loudly bumps another trike, yelling "Ye-ow!" and takes off around the bumped tricycle.

Ginger walks quickly after Tim and calls out, "Tim, stop," as she gets closer to him. He turns around, looks at her and speeds up.

Another teacher, Mary, seeing Ginger and hearing her request, moves to block Tim's path. He stops.

Catching up, Ginger places her hands firmly on the handlebars of the trike and says, "Tim, bumping is not safe. You will need to get off the trike until after snack time."

Tim smiles and says "No!" and sits firmly.

Ginger repeats her request two more times, but Tim does not move. Finally Ginger, somewhat frustrated, says, "You are going to get off the tricycle now," puts her hands under his arms and pulls to lift Tim off the tricycle.

Tim keeps his hands on the handlebars and wraps his legs around and underneath the seat, so that when Ginger lifts him, she also lifts the tricycle.

What Does This Case Address?

This case, says Judy Bordin, was chosen to assess the candidate's **problem-solving skills,** as well as awareness of:

- Safety
- Discipline/Guidance Techniques
- Teamwork Issues

How Is The Assessment Made?

The issues raised by the case study may be assessed by asking four types of questions, according to Judy Bordin. She gives examples for each type:

1. **Fact-Seeking**
   - ✓ *Who are the players here?*
   - ✓ *Explain the situation from each one's point of view.*
2. **Analytical**
   - ✓ *How many problems are there? What are they?*
   - ✓ *What might be a possible explanation for the behavior?*
3. **Action**
   - ✓ *What should Ginger do immediately?*
   - ✓ *What should she do in the future?*
4. **Evaluation**
   - ✓ *What are the short- and long-term costs and benefits to those solutions?*
   - ✓ *Are there other resources to help Tim and Ginger?*

This situation is #__ on my "Top Ten List" of most difficult things to handle with children.

How Are Case Studies Presented?

The employer can relate the case verbally during the interview and initiate a discussion.

Or: The candidate may be asked to arrive early to consider a written case study and write a response, to be discussed during the interview.

"If you present it verbally," advises Judy Bordin, "the case should be short and to the point — not with a whole lot of issues attached.

"I recommend giving it in writing, even if you're going to just talk about it. People learn in different ways. You might even want to give it in writing and also read it aloud.

"You can adjust your method to the position you're hiring for. Aides, for example, may be inexperienced and could have trouble tackling the task, but head teachers and directors are likely to have had more experience and can probably handle it more easily."

Group Interviews

The same presentation methods may be used for group interviews.

If the candidates prepare written responses before the interview, they can be asked to discuss the case when they come together.

Interviewing prospects together is a good idea when there are many people to interview, or when a committee is doing the hiring and it's difficult to coordinate schedules, Judy Bordin believes.

"I see a group interview as a step. If a number of people have applied and you've done the paper screening, the group interview can be the next step, and you can screen further after that. Often during a group interview, the 'cream' rises to the top, and those people can be given individual interviews."

Groups are particularly suited to case studies, she adds, because discussion can unfold growing complexity. One participant may say, for instance, "I've had that happen, and then the child's parent came in, too," thereby introducing another element and making the topic more complex.

"In my experience, the ideal is to have three or four participants. If you go over four, it's likely that someone won't get enough of a chance to speak."

What Do Case Studies Show?

When candidates deliberate and discuss case studies, they reveal more than the particular issues addressed by the cases, according to Judy Bordin.

A case study can also help an employer assess how well a potential employee:

- ✓ listens and writes.
- ✓ clearly and persuasively expresses oneself.
- ✓ deals with emotions and conflict.
- ✓ assesses and evaluates his or her own ideas.
- ✓ makes on-the-spot decisions.
- ✓ takes action in each situation.

A case study discussed in a group interview, she adds, can allow the employer to further assess how well each potential employee:

- ✓ discusses his or her reaction to and perspective on the same incident.
- ✓ notices how the case becomes more complex as the discussion proceeds.
- ✓ participates in small group process: Who assumed leadership? Who observed? What other roles — interpreter, questioner and organizer are examples — were adopted?
- ✓ builds constructively on the ideas of others.
- ✓ uses social skills, such as humor, praise, eye contact and appropriate body posture.

Suit The Position

It's important, says Judy Bordin, to use a case that fits the position you're trying to fill.

For a job that, besides working with children, includes significant responsibility in other areas, such as curriculum planning, staff supervision and working with parents, she offers this example:

You are working in a center where all of the children are three or younger.

During the last few days, Dacia has been biting herself and others. Whenever she is frustrated or angry, she will bite herself on the finger or arm or injure other children.

The staff has agreed to pay particular attention to her, but has had limited success in preventing the behavior from occurring. Intervention with firm voices, and even a brief time-out have not seemed to work.

When her mother comes to pick Dacia up, you ask to talk to her. After you describe the behavior, the mother tells you that she has a sure-fire way to stop it. She explains that whenever Dacia bites, she simply bites her back, adding that she gives you permission to do the same.

"This case could assess a potential employee's knowledge of at least five major problems:"

- Age-appropriate behavior
- Dacia biting herself
- Dacia biting other children
- Staff teamwork
- Parent education

The **fact-seeking, analytical, action and evaluation questions** suggested for the case study involv-

ing the tricycle would be appropriate for this case as well. In addition, Judy Bordin suggests asking:

What aspect of this situation is most difficult for you? (Action Question)

How complex is this case? This is a bigger problem than this one incident because . . . (Evaluation Questions)

Variations

Judy Bordin stresses that the case study you use should be tailored not only to the position you're hiring for, but also to what you specifically want to assess.

The case of the boy and the tricycle, for instance, could be rewritten. "If you wanted to emphasize a staff teamwork problem, you could have Mary try to intervene, leaving no room for Ginger to handle the situation. Or you could have Mary be the director. You can also offer several variations: 'What if Mary did . . . ' "

And although they should cover each of the four listed categories and elicit important information, the actual questions can vary widely.

Additional suggestions from Judy Bordin:

- What personal values influenced your choices? (Evaluation)
- How would you rank the problems from most to least important? (Analytical)
- What ethical principles might apply here? (Evaluation)
- What meaning do you take from this case? (Evaluation)
- I would ask for help from _____ because _____. (Action)
- What I'd really like to say but couldn't is _____. (Action)
- "I typically have them complete: 'When things like this happen, I feel _____.' I give them a list to choose from, like 'Unprofessional, Embarrassed, Unhelpful, Frustrated, Unneeded, Bewildered.' You get a good idea of how they can self-evaluate; get in touch with their feelings." (Evaluation)

Another option she suggests: "For more advanced positions; maybe for teacher, but definitely for director or head teacher, an interviewee could be asked to write a case study and bring it to discuss during the interview."

Questions For Judy Bordin

Q Would you recommend using case studies for support staff — perhaps drivers or cooks?

A Yes, it's a great idea.

You could describe appropriate situations: What if a certain mishap occurred on a bus? What if a child came into the kitchen, stood on a chair and insisted on helping you prepare the food?

It depends on what you're getting at; what policies.

Q Should the interviewer give feedback on the candidate's responses; say for instance, that an answer shows insight?

A I think it's tough to be noncommittal, because nonverbally we *do* commit ourselves; by smiling, nodding and other signals.

People have very individual styles. Some interviewers are very responsive. Others just put their heads down and write.

I think it's good to respond. So much in child care is about relationships. Part of the interviewing process is to model behavior.

And there are times when a response is necessary. Clarification may be needed: "Would you do that now or later?" Or you may have to remind them of something: "What about _____ (the person they didn't consider)?"

Q Some people may become flustered. Can the interviewer help?

A You can stop them and give them a chance to review the case again. They may get the names mixed up or misread in some way. It's okay to help them get their bearings.

Q How many case studies do you recommend using for each interview?

A Probably just one. Choose it carefully.

Q How much interview time should be devoted to a case study?

A It usually takes at least fifteen minutes, depending on the complexity of the case and the number of people responding.

Reading, thinking about it and discussion take a

minimum of fifteen minutes. A case like the one about Dacia would take longer because it involves more serious issues.

Q How much of the hiring decision should rest on response to the case study?

A I'm such a proponent that I'd say fifty to sixty percent if the case is chosen carefully and has elements related to the job.

Case studies tell so much about a person's ability to think. I trust them.

Summary

Asking job applicants how they would handle typical situations is an accepted interview technique.

Judy Bordin's idea is to expand and refine that process. A well-conceived, formalized case study can be designed to zero in on the traits, skills, intuition and knowledge that are required for a specific position, she contends, and can greatly increase the likelihood of hiring the right person.

A case study, whether it describes actual or simulated experience, should be very carefully crafted. Each element should be chosen to illuminate an aspect of qualification that the employer considers crucial.

While it will undoubtedly yield insight in several areas, it's advisable to structure the case study mainly around one major concept. The focus might be on particular relationships — with children, with parents, with administrators, with other staff — or on compatibility with school philosophy or policy.

As important as the anecdote are the questions asked about it. They should include **fact-seeking, analytical, action** and **evaluation** questions.

In Part 2 of this article, Judy Bordin will discuss using case studies for staff training.

For more information, contact:

Dr. Judy A. Bordin
Child Development Program
California State University, Chico
Chico, CA 95929-0220
(916) 898-4761

TOPICS FOR CASE STUDIES

Dr. Judy Bordin offers this "beginning list" of possible topics for case studies:

Curriculum
- ❑ Art
- ❑ Literature
- ❑ Computers
- ❑ Environments/ Space
- ❑ Equipment
- ❑ Health
- ❑ Language Arts
- ❑ Science
- ❑ Social Studies
- ❑ Math
- ❑ Movement/ Dance
- ❑ Music
- ❑ Nutrition
- ❑ Play
- ❑ Safety

Families
- ❑ Parent Education
- ❑ Parent Involvement
- ❑ Single Parents
- ❑ Blended Families
- ❑ Multi-cultural Issues
- ❑ Multi-lingual Issues

Exceptional Children
- ❑ Developmentally Delayed
- ❑ Gifted
- ❑ Physically or Mentally Disabled
- ❑ ADD
- ❑ ADHD

Staff Skills
- ❑ Discipline/Guidance
- ❑ Communication
- ❑ Using Community Resources and Services
- ❑ Time Management
- ❑ Delegation
- ❑ Building Team Relationships

Collaboration
- ❑ Public Policy
- ❑ Resource and Referral
- ❑ Licensing
- ❑ Legal Issues

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Child-care Centers Learning Centers Preschools Nursery Schools Kindergartens Intergenerational Centers

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Economizing While Preserving Quality: Interview With Victoria Speaks-Folds, Part 1

Victoria Speaks-Folds, Ed.D., is vice president of education at Tutor Time Learning Systems. She previously held positions as assistant principal of a private school, and center owner and director.

She writes a monthly column for Careguide.com, an Internet search service for quality child care.

In this article, Dr. Speaks-Folds shares ideas on how directors can create and maintain high-quality programs while economizing.

Defining Quality

Meeting licensing requirements is just the beginning. "Rules and regulations are minimum compliance," says Victoria Speaks-Folds. **"I think of it as, the lights turn on and off, the toilets flush and you meet safety standards. It's the threshold of quality, but not the high level that you seek."**

The distance between basic compliance and top quality can be bridged, she says, by prudent decision-making focused on creating the kind of facility you envision.

"Whether you put a center in an existing building that wasn't a center before, or build it from the ground up, you need to know the quality you want to portray.

"The 'personality' of the center is most important. Parents look for a warm, inviting environment, and the director is critical in creating that."

Of the dilemma faced by owners and directors who want to provide top-quality care but have to watch every penny, she says, "Even in a facility where the only sink is down the hall, you can make it work. You may get a portable sink.

"You have to adapt the environment. Even in a square-box room, you can create a fantastic environment.

"I know because I've done it. Twenty-five years ago, we didn't have such good facilities. I've worked in a center with no supplies. We made our own materials that met, and even exceeded the quality of those you can buy.

"Not having an expensive facility and unlimited funds is no excuse not to give children your very best program. You need to use your intellect and experience.

"Know your organizational goals. Be innovative and creative."

Systems Save

"When you have no system," warns Victoria Speaks-Folds, "you have waste — waste of time, waste of staff abilities and waste of resources.

"If, for example, you're constantly running to the corner store for small items, you're wasting money. You should be planning ahead and purchasing in bulk through your vendor.

"And you have to organize upcoming events if you want them to be really successful. You might have a twelve-month calendar that you use only to schedule the preparation steps for each major event.

"You can't exist in a 'today' mode. Organization is the key that will allow quality to exist even though you're being economical."

Maintaining Your Physical Facility

Systematically checking that your building and grounds are in top shape is a major way to ensure quality and save money. Decide how frequently to make each check, and mark specific dates on your calendar. Here are suggestions from Victoria Speaks-Folds:

- Have the **air conditioning and heating systems** checked for efficiency. Be sure the filters are added to the regular cleaning schedule. You may be losing dollars in utility bills.
- If you own your building, have your **roof** inspected to be sure you're not losing cooling or heating due to disrepair.
- Set up a schedule for **outside maintenance**. Include lawn care, sprinkler repair, tree trimming, repair of playground equipment, and similar services. Keep a list of those contractors at hand.
- Conduct your own indoor and outdoor **safety and maintenance survey** once a month to catch problems early and keep major repairs to a minimum.
- Plan a **"fix-it-up" weekend workday**.

Parents are great resources for helping to keep your center in good repair.

Many who can't participate during the week because they're at work are happy to get together during the weekend and lend their personal talents. All you have to do is supply the pizza and drinks. Staff members may want to join in as well.

Some projects you can do together:

- Mulching areas of the playground
- Repainting or touching up indoor or outdoor areas
- Resurfacing playground equipment
- Building, installing or altering new indoor or outdoor equipment

"Parents need to know that their children will be watched. Staff or parents can watch them and do some activity that's fun with them, inside if the work is outside, and vice versa.

"Be sure to serve refreshments and take lots of photos."

Warranties and service contracts are often underutilized because they're not easily accessible. In the same way, repairs are often delayed by searching for a contractor's contact information or not knowing which contractor to call, so that the problems become greater and more expensive to solve. Victoria Speaks-Folds suggests:

- If you purchase a new building, select a **universal service contract** — one that will cover all of your major appliances and your plumbing and electrical concerns.
- Whether for your own building or a leased facility, keep your **warranty information** close at hand, to insure prompt repairs.
- Keep a list of the contracted **repair companies** within easy reach.

Fastidious cleanliness is paramount in maintaining a pleasant, healthful environment. Victoria Speaks-Folds suggests:

- Determine the most **cost-effective professional cleaning service** for your center. It may be a teacher's spouse, a parent or a maintenance company.

Structure a **checklist** to be filled out by the cleaning crew during each visit. Provide space for your comments or special requests.

Safety is a hallmark of quality that doesn't require great expense. For example, Victoria Speaks-Folds

recommends these steps for protecting your facility from fires:

- Invite your local **fire inspector** to check your fire extinguishers, exits, fire alarm system, emergency lights and security systems. Have your teachers participate in the walk-through so that they can gain safety information.
- When conducting monthly fire drills, check **emergency lights** to be sure all batteries are in working order, and make sure that the **exit lights** are lit.
- Provide each classroom with a **floor plan** showing where emergency lights and fire extinguishers are located.
- Be sure to provide all classrooms with **fire evacuation plans**.

Training And Utilizing Staff

Your staff is the most important element of your operation. Training staff members, scheduling their time efficiently, trusting them with decisions and making use of their talents benefits them as well as the center. Victoria Speaks-Folds suggests:

"Utilizing your staff to its fullest provides an economical way of offering additional enhancements to your program."

❒ **To check whether you're efficiently scheduling staff, perform a "fifteen-minute count" procedure for five days.**

Using a chart sectioned off in fifteen-minute increments, assign an assistant or yourself to physically count children and staff in each classroom every fifteen minutes from the time your center opens until it closes.

After five days, you'll know the average number of children entering or departing at any time during the day. Your staff count can then be adjusted accordingly, to be sure you're not over- or understaffed at any part of the day.

Allow for teacher planning, exchange of information between staff shifts, periods when a floater may be needed, and other scheduling details specific to your program.

At first glance, this procedure might seem to be effective just for centers that offer a variety of scheduling choices, such as part-time and drop-in care. However, Victoria Speaks-Folds says, "Even with only full-time enrollment, there are varying schedules. For example, a parent whose child is enrolled full time might pick the child up at 3:30 each day.

"When you close your center at 6 p.m., not everyone who was there at opening time is still there. And not everyone who is enrolled full time is there at 7 a.m., when you open.

"Look even in a full-time school for comings and goings. You may find that you've accessed a great way to discover that you have excess teachers or not enough teachers."

❒ **Evaluate your staff for special talents.**

Does anyone know sign language or a foreign language? Is someone artistically inclined, gymnastically talented or able to play a musical instrument?

These people can perform special assignments — providing the children with collective music time, physical fitness activities, foreign language instruction and the like.

"Utilizing your staff to its fullest provides an economical way of offering additional enhancements to your program."

❒ **Establish a regular in-service feature as a benefit to your staff.**

You or a staff member can produce a calendar of workshops to be presented at your center. You can publicize the events and charge a fee for people from neighboring centers to attend.

Again, tap your staff first for expertise that they can share with their colleagues.

Then look to the community. You're likely to find professionals, representatives of various organizations, and others who would welcome the opportunity to speak about pertinent subjects, either free of charge or for a small fee.

❒ **Recognize and compensate staff for special contributions.**

According to Victoria Speaks-Folds, "Any staff member who goes beyond his or her regular duties should get some form of compensation. It could be time off, conference attendance, money or another form of payment. When you offer compensation, you inspire others to volunteer.

"And when a staff member does something out of the ordinary, you need to share it with parents. You could put a 'Teacher of the Month' feature on the bulletin board, for example.

"Always be sure to take lots of photos of a workshop or other special event, and display them for the parents.

"All of this not only builds the self-esteem of staff members, but also shows parents your commitment to continued education and training."

❒ **Motivate your staff by selecting individual teachers, based on performance, to attend outside workshops, seminars or conferences.**

Those who attend can share what they learned through presentations at in-house workshops.

❒ **Encourage continuing education by posting local training opportunities and selecting staff members who meet established criteria to attend.**

You may determine, for example, that you need more credentialed people, or decide that all lead teachers need to have two-year degrees, and base your choices on those factors.

"Systems need to be established so that your center operates with a sense of continuity and harmony."

Some ways to look for training programs: "You can start with your local licensing liaison. He or she is often aware of educational opportunities.

"And know your community. Participate in local events and get on mailing lists for area agencies that provide training, course work and degrees. You may be an adjunct professor. Make use of such connections."

❒ **Begin a self-study that leads to accreditation by the National Association for the Education of Young Children.**

Beyond the tremendous intrinsic value of accreditation, which by definition develops and enhances quality, the self-study phase encourages staff members to work as a team toward improvement. Contact NAEYC at (800) 424-2460, ext. 360.

❒ **Show confidence in your staff by delegating.**

If a staff member is going to be absent, for example, he or she can make the substitute arrangements, and just call you to tell you who the replacement will be. When you delegate, you build responsibility, team spirit and a sense of belonging.

❒ **Empower your staff. Include it in planning.**

"Systems need to be established so that your center operates with a sense of continuity and harmony. Include staff members in the planning stages of organization so that their ideas can be heard and appreciated."

People work harder to facilitate plans they have helped to create.

Rewarding Staff

Quality is greatly enhanced when staff members feel appreciated. They work harder, and are far less likely to look for other positions. Their positive attitudes make your center better in every way.

Find ways to show that you value staff, keeping in mind that there are many forms of compensation besides money. Just one suggestion by Victoria Speaks-Folds:

Consider inviting your staff for an evening social. You can have a "movie marathon," a craft night or a potluck dinner.

Getting together socially helps to develop team spirit. Before planning such activities, however, be sure that your staff wants them and is able to attend.

In Part 2 of this article, Victoria Speaks-Folds will discuss dealing with vendors, finding free and inexpensive materials, and other ways to economize while preserving quality.

For more information, contact:

Dr. Victoria Speaks-Folds
Tutor Time Learning Systems, Inc.
One Park Place
621 NW 53rd Street, Suite 450
Boca Raton, FL 33487
(561) 237-2218

Including Children With Disabilities: Interview With Susan E. Craig, Part 2

Susan E. Craig, Ph.D., is director, special projects of AGH Associates, a company that helps schools and child-care centers accommodate children with disabilities.

In Part 1, Dr. Craig spoke to administrators about preparing themselves and their staffs for including children with disabilities.

In this part, she continues that discussion, talks about working with an Early Intervention team and shares specific techniques for caring for children with disabilities.

Beginning Steps

Susan Craig suggests that directors take these general steps to begin to prepare staff for working with children with disabilities:

- **Sit down with your staff and come to an agreement on how you see children with disabilities.** "The goal is to make the staff see them as more typical than atypical."

  They should understand that a large part of what they'll be called upon to do for children with disabilities is to remove the barriers that keep them from having the experiences common to other children.

- **Examine your policies, procedures and forms to eliminate inadvertent discrimination.**

  Examples:

  Is toilet training required for moving up? "Children should move with age-appropriate groups regardless of whether they're trained. Be sure nothing is working against that goal."

  Do your brochures specifically indicate that children with disabilities are welcome? "Families are very hesitant to initiate that. They've had a lot of bad experiences because of these babies. They need to know that their children won't be rejected."

- **Look at how you conduct interviews for staff; what attributes you seek.** You can solicit input from current staff by asking what skills they think they have that are good for caring for children with disabilities.

- **Put yourself in the place of a child with disabilities.**

  Are toys accessible?

  "Do toys, books and posters on the walls include children with disabilities — show and talk about them in commonplace ways? A book that isn't about a child with Down syndrome, for instance, may have that child in the story or picture. It's all part of diversity."

  Do simulations. Ask for example, "If I were blind, how could I get around here?"

- **Invite outside people to talk to the staff.**

  In the beginning, it's best to have them discuss inclusion in general, rather than emphasize specific disabilities.

  "Local universities and hospitals usually have outreach programs. You can also try pediatricians, and there are parent groups that provide speakers. Individual parents and other family members of children with disabilities are very helpful, too."

  Later, you can invite speakers to discuss particular disabilities.

  "Before having a person come in to speak, it's a good idea to have each staff member submit three questions. There will be duplicates. That can target the needs the staff has. Give the questions to the speaker ahead of time so he or she will know what to emphasize."

- **Create an advisory board that includes people with disabilities or experts on the subject.** "The former are preferable."

- **Involve parents of children already enrolled in the program.** "Help them to get knowledge. Inform them that children with disabilities will be there, and teach them why. Build support for your inclusive program. You can use our seven-minute video and the manual that goes with it. Each year, invite parents to a meeting on inclusion, so that they become knowledgeable and supportive."

If a director follows these basic steps, how long is it likely to take for the staff to be well prepared and comfortable with the idea of a totally inclusive program?

Susan Craig says, "Generally speaking, with a good director, it should take about six months with our training materials.

"It depends a lot on the personalities of the people. If they're terrified, you may have to take more time. **The biggest step is getting them to want to do it.**"

IFSP

According to federal law, all infants and toddlers with disabilities are entitled to certain services.

Every state receives federal funds to run Early Intervention programs that coordinate the services that each child is to receive from state, public and private agencies.

An EI service coordinator works with the child's family to develop an **Individualized Family Service Plan** and choose a team of service providers to implement the plan. The makeup of the team depends on the child's needs and the goals agreed upon by the service coordinator and family.

Here are examples of IFSP team members, with descriptions of their roles from the "Including All Children" Administrator's Handbook:

- **Speech/Language Therapist**: Deals with oral-motor control, hearing, cognition, language processing
- **Physical Therapist**: Deals with mobility and stability — walking, holding up trunk and head
- **Occupational Therapist**: Deals with fine motor manipulation — grasping, self-feeding
- **Social Worker**: Deals with matching family needs and resources — may help find care for siblings, respite for the parents, financial help
- **Nutrition Specialist**: Deals with dietary needs — oral-motor feeding problems, inability to exercise, balancing medication effects

Joining the IFSP Team

Susan Craig and her colleagues at AGH believe that it's **vital for the child's caregiver** at the center **to be a member** of the IFSP team.

"Early Intervention," she says, "was always supposed to be support for parents. But they've worked mostly in clinical settings. Their goal, for example, would be to have the child talk or walk.

"Our outreach program is trying to get it back to its original intent; to keep the child in the family and help the family to be a functional unit.

"That's one reason we believe it's important to have someone from the child-care center on the IFSP team; to give an idea of the family needs."

Another important aspect of the caregiver's role is to provide information to the team about age-appropriate routines and activities. **And if the caregiver is a team member**, the Administrator's Handbook notes, **the administrator** — "the only one who can commit the center to policies, or commit center resources, and support the caregiver's role on the team" — **should be a co-member.**

Working With Early Intervention

Susan Craig says directors need to understand that they and the caregivers have a great deal of valuable expertise to offer the IFSP team. "Don't get run over by EI," she warns **"Make sure they're not getting too clinical. Routines for child care are child-driven, not clinically driven.**

"A director should pull back, for example, when physical or occupational therapists are coming in with **lots of equipment** instead of using things in the center that have the same components. Or when they're **pulling children out of the classroom** instead of providing support within what's going on.

"They don't need a special swing hanging from the ceiling of the center. They can use the swings on the playground. And instead of using steps that don't go anywhere for therapy, why not use the steps on the playground slide or other play equipment, or on the bus, or those at the center entrance or inside the building?

"The child-care director needs to have confidence. Ask, 'Can't you use what we have here in the same way?' **You want to use the center as a medium, rather than using things from much more sterile environments.**

"Child-care people have to demonstrate that they know what they're doing. Show confidence. Show, for instance, that you know about motor develop-

ment. Help by showing them a plastic slide.

"Therapists don't always have experience with large groups of young children, or they may not have worked with typical children in a long time. The provider can give tips. It's actually common for therapists to have expectations that *exceed* typical development.

"I attended a meeting once about a seven-year-old child in the second grade who had Down syndrome. She had a habit of wiping her nose on her sleeve. After a lot of discussion about it, a veteran second-grade teacher stood up and said she'd had lots of seven-year-olds who did the same thing."

Medical Procedures

Caregivers may fear that they'll be called upon to use special medical equipment.

Some children, for example, are fed through a gastronomy tube, commonly called a G-tube. It is a flexible rubber catheter used to administer food and fluids directly into the stomach. It's needed when, due to a medical condition, a person can't eat in the usual way. There might be, for example, an obstruction of the esophagus, or the person may be unable to take in enough food by mouth for adequate nutrition.

A caregiver is not required to perform medical procedures. Another professional will be responsible for carrying them out.

When they are needed, says Susan Craig, "a community health nurse usually follows the child from the hospital." Besides handling the medical responsibilities, "they can be very helpful. For example, a nurse may provide special toys, like dolls or teddy bears with G-tubes, that become part of the toy corner."

Supporting Your Staff

According to Susan Craig, it's generally easier to care for children with physical disabilities than those with cognition or attention disorders.

"Children with motor problems can be frustrated by barriers and lack of mobility, but those problems are easier to accommodate. You just have to work out a plan to deal with the physical limitations. The director has to convince the provider that the child is safe and healthy despite the disability."

Working with those who have non-physical problems is often more challenging, she adds. **"These are the children who most need routines; need predictable, intentional routine, and you're likely to have more of them than those with physical disabilities.**

"Children with attention-deficit and behavior problems don't have experience in **turn-taking, choice-making** and **using language to get their needs met.** With mental retardation, the aspects of the disability that are found to be the most difficult are **lack of attention, strong need for routines** and difficulty in **processing language.**"

When children in their classrooms have these kinds of problems, caregivers particularly need strong, ongoing affirmation and support. **"The whole presence of an administrator who is a coach is what providers always say helps them become confident.**

"They get worn out. Progress with those children isn't as quick. They need someone removed to tell them, 'You're doing a good job,' and to point out some of the improvements they've helped to bring about."

Giving Children Choices

Regardless of the nature or severity of a disability, Susan Craig and her colleagues emphasize, it is crucial that every child be given choices.

"Including All Children" materials suggest techniques for presenting choices to children who can't express themselves in typical ways.

A newly enrolled child with a developmental disability, for instance, can be taken on a "shopping tour" of the room to see what engages his or her interest. That can give the caregiver a starting point on getting the child involved.

One caregiver describes working with a girl who could only move her eyes. The technique she learned from the child's mother was to hold a toy in each hand, make sure the child looked at each toy, and give her the one on which she fixed her gaze. Gradually, the child learned to make her choices in that way. "It just took patience till she learned to connect eye-pointing with getting something," the caregiver says.

According to Susan Craig, **"When children are given choices, they begin to see themselves as causal factors in cause-and-effect relationships.**

"Children with some types of disabilities can't naturally see cause and effect. They need to begin to demonstrate choices. They need to appreciate the fact that they are causal agents; things aren't just happening to them.

"One of the hardest aspects of having a disability is having parts of yourself over which you have no control. They need to compensate. Often, they've gone through very intrusive medical procedures. They have a critical need to establish a sense that they have some control; are not dependent on the whims of the people around them.

"It's often more effective to offer *forced* choices (*Would you like regular or chocolate milk?*) than *open-ended* ones (*What would you like to drink?*). Children with word-retrieval or other language-related disabilities can't make open-ended choices.

"It also helps to use visual representations; to hold up the cartons of regular and chocolate milk while you're asking.

"Children without choice-making get unmanageable. They don't know they can cause things. They assume that they just happen.

"Cause-and-effect is the basis for inferential reasoning. It is pivotal. Train them to make choices and label the choices they make."

"They have a critical need to establish a sense that they have some control; are not dependent on the whims of the people around them."

Final Words

On actively working for total inclusion of children with disabilities, Susan Craig sums up her advice in this way: **"Just do it. Get the word out. You'll be more than 100 percent glad. You'll improve the quality of care for all the children."**

For more information, contact:

Dr. Susan Craig
AGH Associates, Inc.
PO Box 130
Hampton, NH 03843
(603) 926-1316

"Including All Children" training materials may be ordered from the same address.

Excerpts From "Including All Children" Training Materials

Administrator's Handbook

The "Including All Children" Administrator's Handbook compares the traditional view of child development to a ladder, and current theory to a hopscotch board. This excerpt enlarges upon that concept:

OLD THEORY:
Development Keeps You At One Level

If you can't walk, you stay in the infant room.

If you are 18 months, and kids your age are in the toddler room, it means that you lose all your role models for being 18 months.

For zero-to-three-year-olds it's almost impossible to predict exactly what you may be able to do. But staying on one level may set that limit.

NEW THEORY:
There's Something For Every Kid On Each Square Of The Hopscotch Board

Things are going on in every square of the board.

Some part of that activity may develop pincer grasp. Some part of that activity may develop eye contact — or language, or taking turns, or whatever a child needs.

Every activity breaks down into parts. Some parts are complicated, some parts are basic. That means each activity offers every child something to learn, and something to have fun participating in.

Trainer's Guide

Be sure that children with limited independent movement are in the center of activities and not left off to the side.

It's a good rule of thumb to change a child's position at least once every 20 minutes. This allows the child to observe the environment from different perspectives and reduces the physical stress of being in one position too long.

Extending Caregiver Skills

Each caregiver's module in "Including All Children" has a feature that pairs aspects of the topic that apply to all children with ways they can be extended for children with disabilities.

Here is an example from **Module 1: "Safety — Seeing Accidents Before They Happen"**:

What Every Caregiver Knows: Parents can give you the information you need about their child's individual needs.

What's New: Parents may be afraid to give the impression that their child's needs are difficult.

Caregivers can help parents understand that they want to know the child's needs so they can give that child the best care.

Experienced Caregivers Speak

Throughout the "Including All Children" series, five caregivers talk about experiences they have had and insight they have gained while working in inclusive programs. Here are excerpts:

Module 3: "Environments That Say 'Yes' "

"Basically," said Carol, "our rooms should make kids feel like we do on a day off at the mall. 'Wow, look at that ... I have to try this ... These are wonderful ...'

"If you have kids with disabilities, you need to be sure they are getting that thrill — wanting to try things to see how they work, to handle them.

"That may mean upping the volume of stimulation, or lowering it by focusing on one thing. It may mean helping them move or make the most of limited movement, or limited attention span.

"But you've got to make them feel the thrill that they're surrounded by fantastic things, and they can try them all."

Module 4: "Physical — Children Need to Explore"

"When I think of positioning Willie, I think where's the action and how to get him there.

"If the other kids are exploring water, Willie wants to do that, too. How else can he learn how things feel wet? And how's he going to listen to other children's language, and how can he feel like part of the group?

"There is only one way — he's got to be up at that water table. And he's got to be there when the rest of them are, and he's got to get his hands in it.

"I may put him in a prone stander, or hold him in my lap, or whatever else gives him the physical support he needs. But if I don't get Willie up there, I'm letting him down."

Module 5: "Cognition — Children Learn By Playing"

"Basically, for children with disabilities, you're doing the same things as for the other kids," said Carol. "But you have to make sure they can do the physical stuff.

"They may never be able to pick things up, but with assistance, they can do things in everyday life — they can stir soup, roll a truck, put puzzles together."

"That's the point," said Denise. "Giving them the assisted movement to explore will let them build the concepts just like the kids who are moving on their own.

"That's the way they're going to experience the world."

Module 9: "Families: Getting to the Roots"

"When parents are worried or concerned," said Denise, "be careful you don't make them feel they're failing.

"Ask them to come in and show you something they're doing right — even if you don't need the lesson. Then you can do some modeling for them. Make it an equal exchange so they feel good about themselves.

"Role modeling for parents is a lot of help — getting them in here to watch how we deal with things. But don't forget that we use them for role models as well. They can show us all the tricks they've learned, and all the things they've been taught."

Hiring And Training Staff Using Case Studies
Part 2: Using Case Studies For Training

Judy A. Bordin, Ph.D., is an associate professor in the child development program at California State University, Chico.

In Part 1 of this article, Dr. Bordin discussed using case studies for hiring. Here, she speaks about using the technique to train staff.

Why Use Case Studies?

Judy Bordin believes that case studies used for staff training are valuable in several ways. "They develop **skills** and provide an opportunity for the director to **orient staff to center policies**. They extend expertise and can be **challenging** to even experienced teachers. They encourage each person to look at situations from **everyone else's viewpoint**.

"They help to establish informal support groups. When staff members work together to solve a problem, they begin to see each other as resources.

"Deliberating case studies encourages staff to take a **more active role** in their own training; to participate in their own professional development. They can learn to come to some sort of consensus. They become **empowered**.

"It's also a great development tool for the person who writes the case study. It makes one think through situations."

Just For Teacher Training?

In training as in hiring, case studies may be used with **all categories of staff**, says Judy Bordin. "The relevance depends on what is written. Certain situations may be a little weak for some staff — may involve responsibilities that they don't normally have in their positions. But it's important that they know what the center's policies and philosophy are, so they have some idea of how these matters are viewed and handled by the center."

Therefore, she recommends that the entire staff meet to consider a case study. **"We need some team-building here.** Sometimes auxiliary staff is the least knowledgeable about children. They have very different training. On the other hand, you may find hidden talents — skills and insights you didn't know they had.

"Another reason is that they often get to see what others don't see. **At a bus stop, for example, there are interactions between parents and children that teachers would never observe.**

"We need to include people in those positions as part of the team."

Presenting A Case Study

Here are three methods that Judy Bordin offers for presenting a case study to staff:

- Hand out written copies of the case study and questions relating to it, and ask staff members to write their responses. Have a group discussion of what they've written.
- Follow the same procedure, but instead of discussing the answers right away, collect them and have the discussion at the next staff meeting.
- Hand out the case studies and questions before the meeting, asking staff members to bring their answers to the meeting to discuss.

Why Have Staff Write Responses?

"Writing," says Judy Bordin, "is a very valuable tool in this process.

"I believe that writing helps to develop the **'reflective practitioners'** advocated by Dr. Elizabeth Jones. When you write, you think about your words.

"Another benefit is that writing saves time in a group. When we're writing, we often cross off ideas that first occur to us. When we've considered the case and written our responses, our choices are made already. We bring more sophistication to the meeting.

"Also, I'm a college instructor, so I believe in writing."

Recommendations For Writing

In the first two methods, in which staff members write their answers right away, Judy Bordin recommends allotting from **five to ten minutes** for the writing, "depending on the complexity of the case and the types of questions.

"I've found that people usually take about ten minutes at first, and as they become more skilled at considering case studies, they take less time. But for a more complex case, it takes longer. They need time to read the case and get the situation and characters straight."

In the third method, what is the value of collecting the answers? "The goal is for the director to get **a general idea of the range of responses** and to see where to take it from there.

"Use this very carefully. The director shouldn't dominate the discussion or force his or her opinions on the staff.

"The idea is more for the director to see what **needs** the staff may have; to get some idea of the continuum of responses, in order to be more prepared."

Should responses to be collected be submitted anonymously? "It depends on the staff atmosphere. If staff will feel threatened, you could eliminate names, but that would probably mean that you have problems.

"And I think it's a good idea to hand the papers back and have staff members talk from them. The bottom line is that it's not that important. The director could just say that names are optional."

How Long Should Discussion Be?

Says Judy Bordin, "Depending on the depth of the case, it's probably good to allot from ten minutes to a half-hour for discussion.

"The amount of time should be **based on the complexity** of the case study and how **value-laden** the topic is. A case in which time-out didn't work, where the group is to determine what the next steps should be, may not take as long as a case revolving around values — maybe nudity or bathroom supervision.

"Other topics that can become complex are parenting, cultural diversity — dealing with ethnic practices we see in families — and how to work with children with special needs. Staff may have strong feelings on some issues.

"More than thirty minutes is too much. Even that is a little long. If the discussion isn't finished, the director can stop it and resume a few days later. It gives everyone time to think about it. The director can say, 'Let's set a time to meet again.'

"Waiting for perhaps forty-eight hours gives people time to calm down. Sometimes pairs will talk, or a person may reflect on the question while driving or going about daily life.

"It's important not to sweep disputed issues under the rug, because they're not resolved."

What Does The Director Do?

"The director's role," says Judy Bordin, **"is to be a facilitator;** to ask, 'Why?' and 'What do you think would happen if ... ,' and to sum up: 'Is this what I'm hearing? Are most of you saying ... '

"At the end of the meeting, the director can summarize the discussion and coordinate follow-up.

"He or she may say, 'If a situation like this occurs, we all agree ... '

"If action is to be taken — like changes in policy or a letter to parents — the director can ask people to volunteer to do what is required. If, for instance, the staff decides it should go to a workshop, who will find one, and who will make the arrangements?

"If a secondary issue was raised by the discussion, the director can prompt further action. There may be questions, for example, about whether or not bruises or cigarette burns the teacher saw indicate an abuse case.

"The director may say, 'I hear that not all of us know what we're supposed to do here.' The group may end up inviting a social worker to discuss abuse, or get slides showing bruises and signs of abuse.

"If the discussion indicates the need for further training, the director can ask if anyone knows someone in the field who can talk about that."

Avoiding Pitfalls

While using this technique, Judy Bordin warns, be on guard for these hazards:

- **Competition** among staff members
- The **"fixer-upper"** model, in which the director gives the impression of having all the answers
- Focusing on so-called **"right"** and **"wrong"** answers

"Keep in mind that this is for training and learning, not to show that certain individuals know more, or

that the director does. It's about **learning together, developing together and developing teamwork.**

"Trust that appropriate answers will come through using this technique. **It involves making a determination that your staff is competent; can make decisions and choices.** If they have some concern and are afraid to talk — to give the 'wrong' answer, the technique won't be successful."

Theory X or Theory Y?

The director's attitude is the major determinant of whether the process will succeed, says Judy Bordin.

She points to the work of Douglas McGregor, a leading organizational theorist who in 1960 used **"Theory X"** to represent the **old, authoritarian style** of leadership and **"Theory Y"** to stand for the **new, enlightened style** centered around people's needs and interests.

"Theory X assumes that workers **dislike** their jobs and must be **tightly supervised** — coerced — to complete their tasks.

"Theory Y assumes that workers have integrity and will **work hard** when committed to their jobs; will be ***responsibly self-directed.***

"Directors who tend to follow Theory X — who think they have to firmly control their staffs — are more likely to have problems with staff competition and other undesirable attitudes.

"Directors should understand that they can learn from their staffs."

"The Y-type director does need to provide facilitation and guidance, but believes that the staff can be trusted to devise intelligent and appropriate outcomes.

"Directors should understand that they can learn from their staffs."

Case And Question Guidelines

In Part 1, "Using Case Studies For Hiring," Judy Bordin suggested that to create a case study, a director:

- **Use his or her own experiences with children, parents and staff or, with permission, the experiences of others.** The case study can describe an actual situation that took place or be a composite of several events.
- **Have a clear purpose.** Ask: What topic am I addressing? Does it involve school policies or philosophy, relationships with children; with parents; with administrators or other staff? Emphasize one of the categories.

She recommended four types of assessment questions:

1. **Fact-Seeking** *(Examples: Who are the players here? Explain the situation from each one's point of view.)*

2. **Analytical** *(Examples: How many problems are there? What are they? What might be a possible explanation for the behavior?)*

3. **Action** *(Examples: What should the staff member do immediately? What should he or she do in the future?)*

4. **Evaluation** *(Examples: What are the short- and long-term costs and benefits to those solutions? Are there other resources to help the participants?)*

Varying The Technique

In time, because training is ongoing, a director might ask staff members to take turns in contributing case studies, says Judy Bordin.

"But first you have to teach them the questioning technique. The questions tend to be harder to create than the study itself."

Final Comments

"Staff members may have different needs, based on where they are in their own careers.

"Beginning people probably need more focus on curriculum, while experienced ones are more able to consider deeper issues — involving families, for example.

"When you have a **'mixed bag'** of staff, your case studies may need **certain elements that appeal to each level.**

"I described a case in Part 1, for example, in which a child was biting and her mother suggested that staff bite her back.

"Beginning staff may tend to focus on just the child

biting; what you do when that happens. Experienced people are more likely to realize that the real work to do is with the parent; that what they've learned may indicate further problems.

"For the more advanced, you can also add another part. You might ask what to do under this scenario: The parent says to bite the child back, and the staff member answers, 'We can't do that. It's child abuse.' The parent becomes incensed and takes the child out of the program.

"Considering a case study with several levels fosters **modeling.** With this case, inexperienced staff members learn about communicating with parents when you disapprove of what they do."

A case study may prompt further exploration, Judy Bordin notes. "The director may ask, 'Is this abuse?' The discussion can go in many directions. **It grows out of staff interest.** Motivation is so much better when it does, instead of the director saying, 'We'll have a staff meeting on the rules and regulations on child abuse.' "

Finally: "More experienced staff may need the challenge of writing the case. That might be the most challenging task for them."

For more information, contact:

Dr. Judy A. Bordin
Child Development Program
California State University, Chico
Chico, CA 95929-0220
(530) 898-4761

Staff Teams: Making Decisions

This article is part of an ongoing JCCA series on staff teams.

Empowerment Improves Teams

The more responsibility a team is given and is able to handle effectively, the stronger it will become. Decision-making is at the very core of the team concept.

There is no limit to the kinds of decisions you can entrust to your staff team. Some are: defining responsibilities of individual team members, dealing with absenteeism and other member problems, allocating vacation time, scheduling, recruiting and hiring new members, selecting team leaders, setting performance standards for members, budgeting, training, and appraising team performance.

Train For Team Success

Any group can make small, inconsequential decisions. But if you're going to **truly empower** your team by permitting it to decide on substantial issues, you need to arm it with the knowledge it requires. Both the success of the team and the future of your center depend on that.

First, the team needs any background **information** that is pertinent to the matter at hand.

If for example, members must work within budgetary constraints or other parameters that exist or that you wish to set, they need to know those limits before they begin deliberating.

It is unfair and disrespectful to ask people to spend their time constructing a decision that is sure to be amended.

The second tool a team must have is a **technique** for sound decision-making.

Is Voting The Best Way?

Historically, groups have made decisions by voting.

An issue or problem is presented. Members discuss the matter and suggest various solutions or actions. Then they vote on the proposed decisions, either by voice or in writing. The action or solution the majority votes for is pursued.

Voting is a valid, orderly way to reach decisions, and it can be done quickly.

But it has disadvantages as well. Perhaps the greatest of these is that it fosters "winners" and "losers" — those who voted for the chosen path of action and those who were opposed.

In some situations, "winning" or "losing" is of no consequence, and all members are willing to follow majority rule. But on **important issues** — those that significantly affect people's lives or that involve deeply held principles — problems can develop.

Members who voted against the majority may feel estranged from the group. They may resent being obligated to behave in a way or support a policy that is counter to their convictions.

If those negative feelings are strong enough, the disenchanted members may even sabotage the decision in some way.

Deciding By Consensus

Far and away, consensus is the decision-making technique most recommended by experts who study and work with business teams.

Consensus is an agreement that reflects the thinking of the group as a whole.

How Is Consensus Reached?

Consensus is not the result of voting, although voting can be an interim step, as can brainstorming and other decision-making tools.

It isn't arrived at through negotiation, politics or any form of coercion. No member is expected to "give in" to another or to the group.

Through consensus, a team can combine the ideas of all of its members to fashion new, creative solutions.

Consensus is reached by following these basic steps:

1. The issue is presented, and every team member has the opportunity to express his or her opinion.

2. The team fully discusses the issue and every suggested option. Members disclose aspects of plans that they find unacceptable. New ideas elicited by the discussion are welcomed and considered.

3. The team works on shaping a viable decision, considering all proposals, by themselves and in combination. Elements that individual members find objectionable are eliminated or modified to everyone's satisfaction.

4. An agreement is reached that every member can accept.

Rationale of Consensus

Reaching consensus doesn't mean that everyone considers the decision to be ideal, or even that *anyone* does. It doesn't necessarily mean that what has been decided will be permanently in place.

What it *does* mean is that every team member is **reasonably comfortable** with the outcome and is willing to live with and support it, at least for a specified period of time.

Important underlying principles of consensus:

- The end result cannot violate any team member's values.
- Every team member agrees to give total commitment to the decision.

Benefits of Consensus

After full exploration of a topic, the team may decide that one of the original suggestions is the best course of action. That is a very acceptable outcome.

Often however, the decision is one that no one fully anticipated at the beginning. This is the unique, most promising feature of this method.

Through consensus, a team can **combine** the ideas of all of its members to fashion **new, creative** solutions.

There are other benefits to consensus as well. Among them:

- Everyone is encouraged to express opinions, ideas and feelings. This makes each member feel valued and creates a **healthy emotional environment**.
- All members feel "**ownership**" in the decision, and are thus likely to be highly committed to making it work.
- Team **cohesiveness** is strengthened. Members know and understand each other better, and take pride in what they have accomplished together.
- Perhaps most important: Consensus creates a **win/win situation**. There are no losers.

A "down" side of consensus is that it takes longer than voting and other decision-making techniques. However, it is widely believed to be very well worth the investment of time.

When Consensus Doesn't Work

There may be situations when, despite the honest

efforts of all members, the team cannot reach consensus.

When such an impasse occurs, other means, such as voting, may have to be used as a last resort.

That becomes less and less likely as the team gains experience with and becomes proficient at arriving at decisions through consensus.

Future articles will deal with other ways to guide and strengthen staff teams.

If your staff works as a team, and you'd like to share your experience and observations with your colleagues, please contact Christine Kalbaugh.

I Am Your Child

National Conference

JCCA is a proud participant in the national *I Am Your Child* campaign, which is dedicated to making America aware of the significance of the first three years of life.

In 1996, Families and Work Institute held a national conference on brain development. The conference was one of the first steps in, and serves as a research base for the campaign.

It brought together one hundred fifty leading brain scientists, child development and early education experts, business leaders and policy makers to discuss the latest research and its implications.

The institute is a nonprofit organization with the stated goal of "finding research-based strategies that foster mutually supportive connections among workplaces, families, and communities."

Ways To Get Involved

In response to requests from people and organizations for concrete ways they can help to achieve the goals of the campaign, the institute gathered suggestions from leaders in diverse fields.

The result was "Early Childhood Action Tips," a set of specific lists showing how organizations and individuals in all walks of life can contribute to the healthy development of young children. They are part of a series of community mobilization materials.

Nina Sazer O'Donnell, the institute's director of community-life programs, who developed the suggestions, writes: "Some of these action tips are simple and practical. They are geared to immediate results and can be acted on right away.

"Others are broader in scope and require more sustained effort. They seek change over the long haul.

"Any of these suggestions can be adopted — or adapted — or used to spark creative thinking about how to improve early childhood programs and services in your state or community."

How Can Your Center Help?

Here are the institute's specific action tips for those in early care and education:

- **Educate families, staff and the public about the importance of the first years of life. Make a concerted effort to reach those who are not fluent in English or are isolated from the community by geographic, cultural, social, or economic factors.**
- **Involve a wide range of families and community members in designing and evaluating programs and services.**
- **Collaborate with other service providers and community partners on an ongoing basis to expand, coordinate, and improve early childhood programs and services. Share newsletters, sponsor shared staff training or develop new projects together.**
- **Make facilities safe and inviting for young children and their parents and caregivers.**
- **Enhance the quality of the early childhood services through staff development, national accreditation, and ongoing evaluation and improvement efforts.**
- **Participate in community efforts to define and improve the quality of services for young children and their families.**
- **Establish or contribute to "one-stop" resource centers to link families with appropriate services.**
- **Make collaborative efforts to help parents identify and seek early assistance for young children with disabilities.**

JCCA recommends presenting these tips at staff meetings for discussions on how your center can help to achieve the aims of the *I Am Your Child* campaign.

For more information, contact:

I Am Your Child
335 North Maple Drive, Suite 135
Beverly Hills, CA 90210
(310) 285-2385

Families and Work Institute
330 Seventh Avenue
New York, NY 10001
(212) 465-2044

Book On Infant and Toddler Development

In **"Baby Steps: The 'Whys' of Your Child's Behavior in the First Two Years,"** Claire B. Kopp, Ph.D. shares much of what she has learned in her almost thirty years of research as a developmental psychologist.

The book's approach is not to dictate strategy to parents, but as its subtitle indicates, to help them understand their children's development so that they are armed to make intelligent decisions. In the preface, the author writes:

"There are plenty of books that offer prescriptions about how to care for babies and young toddlers, but ultimately parents have to choose which advice to follow. It has been my experience that parents are best able to take advantage of such information when they understand when, how, and why their child's behavior changes."

"Baby Steps," which was chosen as one of the ten best parenting books of 1993 by Child magazine, is an excellent resource to share with thoughtful, intelligent parents in your program.

JCCA also highly recommends that every infant and toddler caregiver read it as part of training.

A great amount of vital information is presented in 279 pages, within a skillfully organized format that draws the reader forward.

Without excessively simplifying the material, the author conveys developmental theory and research findings in a non-technical, thoroughly readable style.

How The Book Is Arranged

Indicative of the planning that went into the book is the **Contents** section.

By listing under each chapter heading behavior typical to the age covered, it serves as a brief overview of the first two years of life, and a quick reference source.

The first chapter is a fourteen-page **"Miniguide"** that outlines basic principles of child development theory and defines professional terms for the layperson.

The rest of the text is divided into sections:

- Birth to three months
- Four to seven months
- Eight to twelve months
- Second year

Each section begins with a **Preview** that broadly describes typical development during that stage, and ends with a **"Developmental Overview,"** which reviews in chart form developmental highlights of each month within the period, and advises "How to be Helpful" and "When to Seek Help."

Chapters within the sections focus on the important events in a baby's life, month by month in the first year and in three-month intervals for the second. The final chapter summarizes the first two years and gives a preview of behavior to expect in the third.

Each chapter has:

Milestones typical to the age

Average **lengths** and **weights**

"Snapshot," a word picture of the stage that highlights developmentally significant behaviors

"Images of Development," describing progress in seven key areas of child development: ***Motor, Perception, Language, Cognition, Social, Emotions, Sense of Self***

Highlighted **Hints** — practical suggestions for fostering the skills developing at that age

"Developmental Close-up," an in-depth discussion of an early development topic that is particularly relevant for the stage

Throughout, the author writes in a conversational, personal style. Often, she uses her own professional experiences to illustrate points.

At the end of the book are:

"Charting the First Two Years," a month-by-month listing of developmental milestones; **"The Birthday Party,"** a tool for comparing development at one, two and three years of age; sections on **safety, further reading** and **references**; and an **index**.

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W. H. Freeman and Company
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(800) 877-5351

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